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COMMUNICATION AND DECISION MAKING DURING CHILDBIRTH

by

SUSAN RUTH BEISCHEL ©

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Susan Beischel

323 Oakfern Crescent S.W.
Calgary, AB., Canada
T2V 4T3

Date: 03 October 1997

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled COMMUNICATION AND DECISION MAKING DURING CHILDBIRTH submitted by SUSAN RUTH BEISCHEL in partial fulfillment of the requirements for the degree MASTER OF NURSING.

Peggy Anne Field

Dr. P.A. Field (Co-Supervisor)
Professor Emerita

Marion Allen

Dr. M. Allen (Co-Supervisor)
Professor

Iris E. Campbell

Professor I.E. Campbell
Associate Professor

M. Haughey

Dr. M. Haughey
Professor

Date: 2 October 1997

ABSTRACT

In this study, the researcher explored women's perceptions of their expectations and experiences of decision making and communication during childbirth to increase understanding in these areas. The researcher's goal was to provide theoretical analysis of the experiences of childbearing women in order to expand current knowledge for health care professionals assisting them. This could lead to the implementation of appropriate client-centered care.

Participants were recruited by notices in physicians' offices and an advertisement in a community paper. Ethnographic techniques were used for collecting and analyzing data obtained in the antenatal and postpartum interviews with 12 primary and two secondary participants. One labor and birth was observed by the researcher. Participants ranged in age from 25 to 39 and seven had previous birth experience.

Women identified expectations for themselves, their labor support persons, and health care professionals. Some participants wanted to adopt passive roles and others wanted to collaborate with their caregivers in decisions affecting their care. Five behaviors which reflected women's actual involvement in decision making were self-confidence, confronting issues and concerns, expressing thoughts and feelings, considering self to have health care rights, and making own choices. Women sought control over the uncertainties of birthing related to possible unexpected events and loss of their identities in the hospital environment. Communication in decision making during childbirth was associated with patterns of effective and ineffective communication, and the development of relationships with their caregivers. Effective communication included information-giving, reassurance, explanation, and attending which facilitated and encouraged sharing throughout the relationship. Ineffective communication including lack of continuity of care, nurse and institutional-related factors, hindered the formation of a relationship and led to the participants perceiving that they were passive recipients of care.

Implications for education, research, and clinical practice are recommended. There is a need to provide health care professionals with knowledge related to decision making skills and the understanding that expectant women vary in their self-perceived needs and expectations. Care providers need to assess and identify their own decision making and communication skills in order to increase awareness of the impact these skills have on enabling or inhibiting women to be involved in their care. Women want more information on their status and reassurance on how they are progressing during labor and birth. Care providers must encourage their clients to communicate their preferences throughout the childbearing cycle or upon admission to hospital. Women need the opportunity to discuss their perceptions of their birthing experiences. Future studies should be completed to further develop knowledge related to women's experiences of decision making and communication during childbirth.

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CHAPTER ONE

INTRODUCTION

Statement of the Problem

Although the basic process by which women give birth has not changed throughout history, the context within which childbirth occurs has changed significantly. The context of childbirth is influenced by the prospect that childbearing women and health care professionals possess two worlds of expectation, knowledge, and perception that are qualitatively diverse (Hayes-Bautista, 1976). Communication patterns and decision making roles are delineated by the behaviors of both women and health care providers in childbirth.

Prior to the twentieth century birth generally took place in the home. Women with varying knowledge and experience supported one another through the birth process often traveling great distances to assist relatives and friends. Battling with conditions that complicated pregnancy, birth and recovery, childbirth was associated with fear and danger. Motivated by the reality of death, women moved out of the home and into the hospital setting for physician attended births (Oakley, 1984). Obstetrical medical management promised women of every socioeconomic level safer, faster, and less painful delivery of their children.

The 'medical model' of childbirth, firmly established in the 1900's, defined pregnancy and birth as a pathologic process in which intervention and complete authority by the physician was not only desirable, but also necessary (Leavitt, 1986). Physicians were responsible for monitoring and facilitating the childbearing 'patient's' recovery from a potentially disastrous event (Oakley, 1984). Successful birth outcomes were objectively measured by maternal and infant mortality and morbidity rates (Oakley, 1980). Women were denied information and deemed incapable of making knowledgeable decisions about their bodies (Romalis, 1981). Childbearing women relinquished control to experts and remained relatively ignorant of the basis for decision-making (MacIntyre, 1977).

Dissatisfaction with the medical model became evident in the 1960's. The ideological combination of the women's movement, natural birth movement, and consumer health movement challenged the medical definition of childbirth (Kirkham, 1989). Birth emerged as a significant and transformational life event, rather than a pathologic and medicalized event (Arms, 1994). Childbirth became conceptualized as the unification of women's minds and bodies; beliefs focused on the expectations, control, and desires of women (Oakley, 1984).

Alternative models of childbirth, such as 'natural birth' and 'midwifery', emphasized the need for women to be informed, strong, assertive, and confident in order to assume responsible parenting roles (Arms, 1994). Advocates perceived alternative birth models as ideal in that they facilitated open communication, information sharing, and active participation in decision making between birth participants (Rooks, 1978; Damsma, 1994). Inadequate information and lack of input into decision making are two factors which have been associated with women's perceptions of a negative childbirth experience (Field, 1985; Kirkham, 1989).

Presently, despite increasing reports of dissatisfaction, the medical model of childbirth has predominantly influenced the social context within which women give birth in North America (Jordan, 1978). Critics of the medical model suggest that childbirth facilitates the needs of the nurses, physicians and the institution rather than those of laboring women (Arms, 1994). Alternative models of childbirth have only recently been recognized and legislated in

Canada and occur outside the conventional arena. Despite this fact, women need to continue to seek 'alegal' midwifery care to enhance choice and collaboration in their own care (Damsma, 1994).

Davis-Floyd (1992) identifies childbirth as a rite of passage. Oakley (1980) defines childbirth as a significant life change event which carries with it tremendous emotional, psychological, physical, and social implications for those who engage in it. Women seldom forget their childbirth experiences and are able to recollect specific details several years later (Arms, 1994; Harper, 1994). Thus, negative birth experiences may have profound psychological implications on childbearing women beyond the immediate postpartum period and include decreased maternal self-esteem (Oakley, 1977), postpartum depression (Oakley, 1980) and impaired bonding (Harper, 1994).

The factors which influence perceptions of the childbirth experience must be further explored in order to educate health care providers and to provide quality care to childbearing women. Two significant factors which have been identified in the literature and appear to influence a positive childbirth experience are communication and participation in decision making.

Purpose of the Study

Despite studies which have addressed communication and decision making, little is known about women's decision making and communication behaviors, beliefs, and practices during labor and birth. Decision making was identified as a component in several studies of satisfaction, information-giving, mastery, maternal expectations, territorial boundaries, choice, and control. However, these studies focused on other variables and outcomes rather than on understanding the behaviors of decision making within the context of labor and birth.

Previous research, which has included findings on communication patterns, indicate that communication between health care providers and childbearing women is frequently inadequate. The most significant communication study to date is one conducted by Kirkham (1989), who observed the flow of information between 113 laboring women and their midwives and reports an "immense, sad, common ground between midwives and women in their care" (p.137). Although this study examined a different cultural system, conducted in the United Kingdom and focused on women and midwives, these findings have significant repercussions for satisfying childbirth experiences.

Factors which inhibit women's communication patterns and their participation in decision making regarding their care have been identified. Health care professionals and client interaction appeared primarily directed toward achievement of organizational goals. These observations raised several significant questions, with implications for both clients and health care providers (Beaton, 1990). Beaton asked: First, are health care professionals acting as client advocates by clients participation in decision making during childbirth? Second, are women encouraged by health care professionals to structure their childbirth experience in a meaningful manner? Third, whose interpretation and definition of the labor and birth scenario predominates?

In reviewing the research on communication and decision making it was evident that the perceptions of expectant women's needs during labor and birth have not been considered. Exploring the emic perspective of decision making and communication during childbirth can increase awareness of women's needs, reflect on communication patterns in client interactions, and provide direction for health care providers to plan and implement appropriate client-centered care.

In this study, the researcher explored women's expectations, experiences, and perceptions of decision making and communication during childbirth. This exploration among expectant women is essential so that health care providers may develop an understanding of women's perspectives and facilitate their childbirth needs in a holistic, authentic, and meaningful manner.

Research Questions

The following research questions were formulated to guide the research process:

1. What are women's expectations of their participation in decision making and communication during childbirth?
2. How do women describe their participation in decision making during labor and birth?
3. How do women describe their communication in decision making with health care providers during labor and birth?

Definition of Terms

For the purpose of this study, the following definitions apply:

Decision making is defined as the conscious and deliberate act of selecting among two or more possible alternatives for a prospective action. A decision is always future oriented, regardless of the time period occurring between the act of choosing and realizing the choice (Kim, 1983).

Communication refers to the verbal or non-verbal act of exchanging information or messages between or among participants (Drysdale, 1993).

Childbirth is realized as the point at which the woman is admitted into hospital in established labor until the fourth stage of labor.

Organization of the Thesis

This thesis is structured in five chapters. In Chapter One the statement of the problem, the purpose of the study, research questions, and the definition of terms are presented. Chapter Two comprises a review of the literature relevant to the study of decision making and communication during childbirth. Chapter Three provides a complete description and rationale for the design and methods utilized in the study. Included in this chapter is a detailed discussion of the decisions of the researcher regarding sample selection, procedures for data collection and data analysis, measures implemented to increase reliability and validity, and the protocol used to ensure ethical conduct of the research.

In Chapter Four the findings of the study are presented. The characteristics of the sample are described. Participation in decision making and communication between participants and health care providers during labor and birth which emerged from the data are descriptively explicated.

These findings are discussed in Chapter Five, utilizing relevant literature for grounding of the data. The thesis concludes with implications of the study and recommendations of this researcher both for health care professionals and for further research in decision making and communication during childbirth.

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

A search on the CD ROM databases (CINAHL, Medline, Health Lit) was conducted to orientate the researcher to literature on decision making and communication in childbirth. Literature on decision making and communication in childbirth was reviewed to examine previous research with respect to content, assumptions, and context.

Decision Making in Childbirth

In reviewing the literature there was little research in which decision making during childbirth was the central variable. It was identified as a component in several studies related to satisfaction (Brown & Lumley, 1994; Cranley, Hedahl & Pegg, 1983; Davenport-Slack & Boylan, 1974; Field, 1985; Jacoby, 1987; Seguin, Therrien, Champagne & Larouche, 1989; Sullivan & Beeman, 1982); mastery (Humenick & Bugen, 1981; Shainess, 1963; Willmuth, 1975); maternal expectations (Beaton & Gupton, 1990; Heaman, Beaton, Gupton & Sloan, 1992; Mackey & Lock, 1989); territorial boundaries (Laryea, 1992); and choice (Annandale, 1987; Richards, 1982).

The variable of control was noted to be prevalent within decision making research and literature. In fact, it frequently appeared in the literature to be synonymous with decision making. To provide insight into the body of knowledge, this literature will be presented and discussed.

Control was defined as the ability to have a 'sense of control' in the interpersonal relationships with the health care providers (Chute, 1985; Davenport-Slack & Boylan, 1974; Willmuth, 1975). Women perceived themselves 'in control' if they felt they were active participants in childbirth rather than passive recipients of care. Being active participants meant that the women felt they were able to negotiate and influence decisions during labor and birth. This sense of being in control seemed closely related to women's perceptions of positive childbirth experiences.

Loss of control was also associated with participation in decision making. Butani and Hodnett (1980) used a psychology-based model of control to determine women's perceptions of their labor experiences. A frequently cited unpleasant aspect of the labor experience was 'loss of control'. The experience of control was related to subjects' concerns about participation in decision making. The authors emphasized in their findings that not all women expressed a desire to be in control, thus supporting the rationale for individual assessment of each woman's desires in labor.

Littlefield and Adams (1987) also found that women varied in the amount of nurse involvement and amount of participation in decision making expected during childbirth. The authors noted that some women reported a great reliance and dependence on health care providers and health care institutions.

In contrast, evidence for control of the childbirth experience and an active role in decision making is found in the literature examining why women choose home birth. Many authors who investigated home births found that the desire to maintain control over the childbirth experience and the desire to be an active participant in the experience were major factors in choosing home birth and alternative birthing centers over hospitals (Conklin & Simmons, 1979; McClain, 1983; Schiff & LaFerla, 1985)

Throughout the non-research based literature, labor and birth preferences have been identified. According to various childbirth experts and authors, women experiencing normal labor and delivery desire, and should participate in collaborative decisions concerning every possible intervention during labor and birth (Arms, 1994; Balaskas, 1984; Carty & Tier, 1989;

Harper, 1994; Kitzinger, 1979; Odent, 1994; Simkin & Reinke, 1980). Although these assumptions may be reflective of women's desired involvement in participating in decisions influencing their care, there are few formal studies to support these opinions.

Findings which support these opinions were reported by Field (1985). She reports in her findings that women felt it was important for them to participate in decisions related to privacy, ambulation, and pain medication. As well, when parents received inadequate explanation regarding procedures and interventions they were frequently apprehensive and did not trust decisions made by health care providers.

A national survey was conducted by Jacoby (1987) who randomly sampled 1920 women with a questionnaire approximately four months after birth to determine their preferences for labor and birth. The participants were asked if prior to their labor and delivery experiences they had desired or not desired a certain procedure to be done. Several inconsistencies in responses by the women reflected the changes in preferences regarding their experiences. Things they had not particularly wanted prior to their labor and delivery (i.e. medication) may at the actual time of labor and birth have become desirable. The authors assumed that the responses may have reflected a rationalization of the experience so the women could live with what happened to them. This assumption may be speculative as the experience of labor may have been different for individual women in the study.

Sullivan and Beeman (1982), developed and sent questionnaires to 1900 women who had live births. The questionnaire contained a series of questions related to whether or not the women had wanted certain procedures and if they had them. Those items with the greatest discrepancies between what women wanted and what they perceived as getting were: choice of atmosphere, freedom to move around, fetal monitoring, and the presence of family members. The authors also found that many women who offered highly negative comments on the questionnaire, evaluated overall labor and delivery care as satisfactory. They concluded there was a reluctance in women who have given birth to criticize care providers.

Shaw (1974) analyzed maternity care in several urban hospitals and found through participant observation that women played little part in decision making during their intrapartum care. In Danzinger's (1979) ethnographic analysis of two postnatal wards, it was concluded that neither staff nor the women requested large amounts of input into the decision making process. Consequently, diminutive opportunities for collaborative decision making were presented during these interactions. The results do raise significant questions concerning how women perceive their decision making roles to be in relation to childbirth.

It was noted from the literature that numerous factors inhibit women from taking an active role in decision making. One factor that limits decision making is the hospital itself. As a large institution which provides service to many individuals, a hospital requires policies to maintain its internal organization and functioning. Policies are not often developed to satisfy the self-perceived needs of individual clients (Beaton, 1990). Within hospitals, the rules of the labor and delivery unit also constrain the expression of individual preferences (Beaton, 1990; Richards, 1982). Kirkham (1989), reflecting upon the extreme medical nature of an obstetrical unit, noted "the 'patient' was controlled, admitted, processed, delivered and then wheeled out of the ward" (p.131).

Conflict may arise when health care providers believe that attempts by expectant mothers to share in the decision making regarding their care indicate a lack of trust in the care providers (McKay, 1988). Health care providers may see a woman's wishes as a personal insult or threat, although the intent of the woman could have been merely to define her perspective and needs.

There is also the view by some health care providers that safety is the fundamental issue in childbirth. Richards (1982) purports that health care institutions and professionals regard emotional comfort and satisfaction as secondary to the important issue of safety. It has been implied that alternatives suggested by women, in their desire to make decisions during the childbirth experience, tend to disregard safety. From the review of the literature, it is evident that the issues that were identified as important for women to participate in during childbirth were not life-threatening.

Communication in Childbirth

Upon review of the literature, it was evident that little research exists on communication between clients and health care providers in childbirth. Despite this fact, certain international studies have resulted in some interesting findings.

Kirkham (1989) observed 113 women and midwives in hospital to explore their communication patterns during labor and birth. This author reported that two communication patterns emerged and appeared to parallel women's and midwives perceptions of information-giving in childbirth. One pattern included expectant women's desire for information with which to orientate themselves to the labor ward and the stages of labor. The other pattern evident was inconsistency in the information provided to women from the midwives. These patterns reportedly created frustration and anxiety regarding midwives provision of care and women's procurement of care.

Various factors which influenced the flow of information from the midwives emanated from the study data (Kirkham, 1989). The factors included: labeling of women by their social class (providing detailed information solely to women of higher education or socioeconomic status); the inhibiting effect of senior staff; 'verbal asepsis' (in which conversations were brought to an end without answering questions); the inexperience of junior midwives; 'routine patter' (in which a considerable amount of information was initially provided to women, often referred to, but seldom repeated); reassurance provided to women when midwives felt unable to give information; self-reassurance (whereby midwives reassured themselves that women's needs were being met); and medical jargon.

In a random survey of postnatal women in the United Kingdom, Fleissig (1993), suggested that physicians and midwives have difficulty communicating with some groups of childbearing women. Groups less satisfied with the adequacy of information provided to them were first time mothers, single mothers, multigravidas under 30 years old, and those belonging to ethnic minority groups. Most women reported satisfaction with the amount of information provided by health care providers in childbirth and indicated they were pleased with their care and management of childbirth. Just under 20 percent of the women surveyed would have liked more information and explanation from their health care providers and reported 'anxiety' caused by poor communication. This is still, however, a significant number of childbearing women.

Beaton (1990) recounted in a verbal-interaction study that nurses and childbearing women communicated from two different and seldom overlapping centers of knowledge and experience. Nurses established and maintained control over the definition of the childbirth experience. As well, the perspective of laboring women was seldom acknowledged as relevant. The author concluded that presumption of knowledge and failure to determine women's perspective of childbirth can have a negative impact on the provision of client-centered care.

Summary

Examination of the literature on communication and decision making during childbirth has determined that further research is necessary in order to obtain women's perspectives. Decision making was an obscure component in several studies related to satisfaction, mastery, maternal expectations, territorial boundaries, choice, and control. Studies which investigated women's preferences during childbirth reported inconsistencies in what women expected to receive and what they actually received in labor and birth. It was also noted that several institutional-related elements often prevented women from participating in making decisions related to their care. Factors which hindered the flow of information between midwives and childbearing women in the United Kingdom were identified. As well, physicians and midwives were noted to have difficulty in communicating with some groups of childbearing women and that nurses seldom acknowledge the perspective of childbearing women as relevant. To date, no research has explored women's expectations and perceptions of decision making and communication during childbirth.

CHAPTER THREE

METHOD

Qualitative Methods

There is one best research method for answering each research question (Field & Morse, 1985). Significant criteria to consider in selecting the method are: the purpose of the study, the questions to be answered, and the nature of the participants in the study. As such, the assumptions, purpose, and interest of the researcher drive the selection of method and must be consistent with the method chosen (Harding, 1987). This is the most important clarification and decision in the research process as the researcher is guided through subsequent decisions by the selected method (Field & Morse, 1985).

A qualitative, exploratory descriptive design, utilizing ethnographic interviewing and analysis was utilized to answer the research questions. Qualitative methods are most appropriate to identify and describe a phenomenon from the perspective of the people experiencing it (Field & Morse, 1985). From the outset it was recognized that women's perceptions of their participation in decision making and communication in childbirth has not been holistically explored. Consequently, an exploratory, descriptive study using ethnographic methods was selected as suitable for the first level of inquiry (Field & Morse, 1985).

Ethnographic studies examine the native's perspective and are a means of gaining access to the values, beliefs, and practices of a culture (Field & Morse, 1985). Aamodt (1989) describes ethnography as a method of collecting, describing, and analyzing the ways in which human beings categorize the meaning of their world . Ethnography is used to elicit answers which are contained within the subjective perceptions of the participants.

Initially it was intended that both interviews and observation would be used. It was found to be impossible to conduct the observation because of 'gate-keeping' from the health care professionals who would potentially be involved in providing care for women in this study. Eighty one percent of the health care professionals at the selected institution returned their forms indicating that they did not want to be observed while providing care for participants in the study. The researcher also received several written comments on these forms which primarily reflected care providers' anxieties and concerns associated with recent changes in the health care system. These comments included: staff "layoffs"; "bumping" of experienced nurses off the labor and birth unit; the influx of many inexperienced nurses onto the unit who required a great deal of supervision from experienced nurses and statements that nurses were not prepared to do "one more thing" as they were already "pushed" to their limits. Other comments such as "big sister will NOT be watching me" resonated feelings of mistrust and suspicion that the researcher would be evaluating the standard of care that they provided for women during childbirth. As a result of this feed-back, it was determined by the researcher and her Thesis Co-Supervisors that observation of every participant during childbirth would be virtually impossible and that the method of data collection would primarily be through interviews.

Research Design

This study focused on a group of 14 women to determine their expectations, experiences, and perceptions of decision making and communication with their health care providers during labor and birth. As childbirth is a unique experience this inductive approach permits the emic perspective of childbearing women's decision making and communication to unfold.

Setting

All, but one of the participants in the study birthed on the labor and delivery unit in a large, urban teaching institution in Alberta, Canada. Interviews were conducted at the convenience of the participants. Twelve of the 14 participants requested to be interviewed in their homes and two indicated a preference for another setting, citing privacy and convenience as reasons for their preferences. One participant arranged to be interviewed at a University building and another chose the researcher's residence.

Sample

The sample was one of convenience (Morse, 1991). Fourteen women (12 primary and 2 secondary participants) who volunteered for the study and met the inclusion criteria were selected as participants. Criteria for inclusion in the study were:

(a) women who were in the last four weeks of pregnancy
(b) a pregnancy uncomplicated by medical or obstetrical complications (i.e. 'low-risk' pregnancy)
(c) women planning their birth at the selected health care institution
(d) ability to speak and understand English

Labor onset may have been spontaneous or induced and the type of delivery either spontaneous, assisted (forceps or vacuum extractor), or cesarean section, as in these scenarios women may have the opportunity to provide input in decision making.

An element of self-selection is involved in a sample of convenience (Morse, 1991) and was evident in this study. The research design included one method for the recruitment of participants. A 'Study Notice' (Appendix A) was posted and 'Letters of Information for Potential Participants' (Appendix B) were available in the waiting rooms of two obstetricians and two general practitioners, who had consented to participate in the study and who had privileges at the selected health care institution. Volunteers were instructed to telephone ~~the researcher~~ to obtain additional information. Due to a lack of response to this method of recruitment, the researcher and her thesis supervisors decided to implement an alternative recruitment method which involved advertising in a local community paper and inviting interested respondents to telephone the researcher. The methods of recruitment and respondents are presented in Table 3-1.

Eleven women responded to the notices posted in physicians' offices and phoned the researcher to express their interest in participating in the study. The researcher explained the inclusion criteria and as much as possible, attempted to assess each respondent through the initial telephone discussion for the qualities of a "good" informant, identified by Morse (1991b) to be someone who "is undergoing the experience... is able to reflect and provide detailed experiential information about the phenomenon... willing to share the experience... (and has) sufficient patience and tolerance to explain" (p.132). It was determined by the researcher that eight of the respondents fitted the needs of the study and an appointment for an interview was arranged.

Of the eleven respondents, two women were not interviewed and were subsequently referred to a local midwifery collective when it was assessed by the researcher and mutually agreed by the volunteers that they were seeking labor support for their impending births. The third volunteer was referred to a Childbirth Educator as she was seeking information concerning childbirth.

Ten women responded to the media advertisement and telephoned the researcher who assessed their suitability as research participants according to the established criteria for inclusion. Of the nine respondents, six women were determined to be suitable participants and a 'Letter of Information' (Appendix B)

Table 3-1

METHODS OF RECRUITMENT AND RESPONDENTS

Method of Recruitment	**Number of Respondents**	**Respondents Accepted**	**Respondents Not Accepted**
Study Notice in Physician's Offices	11	8	2 referred to Midwifery Services 1 referred to Antenatal Educator
Study Notice Advertisement in Local Paper	10	5	4 referred to Midwifery Services 1 respondent sent a 'Letter of Information', but did not call to arrange interview

NOTE: An additional participant was known to the researcher and volunteered for the study.

was mailed to their residence, instructing them to phone the researcher to arrange an appointment for an interview if they were still interested in participating in the study. This additional step was included to ensure that the participants had an opportunity to read the details of the study and to make an informed choice regarding their participation in the study. Four volunteers were not interviewed and referred to midwifery collectives as they were seeking labor support for their imminent births. One respondent who received the printed information did not call the researcher to arrange an interview.

In a study by Field, Campbell, & Buchan (1985) it was found that parturient women often had gaps in recollection related to childbirth and the labor support person often prompted women to provide information that they did not remember. For this reason, during the initial telephone conversation, the researcher invited the participant's labor support person to participate in both the antenatal and postpartum interviews. Six labor support people participated in both the antenatal and postpartum interviews, often acting as 'prompts' to remind the participants of specific birthing details and to validate birthing experiences.

Sampling was determined to be complete when the researcher heard repetition of content in relation to communication and decision making during childbirth. After interviewing the twelfth woman, repetition of data in relation to the identified concepts and experiences had occurred; no divergent concepts or themes were apparent.

Data Collection Procedures

The method of data collection in this study was guided interviews and there was one opportunity for participant observation during labor and birth. Each participant also completed a 'Biographical Data Form' (Appendix C) which provided structured data on demographic and antenatal information. Primary data were collected over a period of 15 months, from September 1995 to early November 1996. Interviews to validate the researchers interpretations of the data took place in December 1996. One secondary participant was recruited in the same manner as the primary participants and the other secondary participant volunteered to participate after hearing of the study at the Faculty of Nursing, University of Alberta.

Twelve primary informants participated in this study for a total of 28 antenatal and postpartum interviews. An antenatal interview was conducted with 11 primary participants between 36 and 40 weeks gestation while they were anticipating their labors and births. One primary participant was not interviewed in the antenatal period because an interview prior to her labor and birth could not be arranged. A second interview was completed with all participants 13 to 45 days postpartum to accommodate the transition home with baby. A third postpartum interview was conducted with five of the participants to clarify data which was previously discussed. Six of the informants' labor support persons participated in both the antenatal and postpartum interviews and one labor support person was involved in the antenatal interview. Only one labor and birth was observed by the researcher, as she was supervising a student on the unit at that time.

One secondary participant was selected in the same manner used to obtain the initial sample and the other secondary participant was a colleague who was aware of the researcher's study, and had recently given birth in another institution. Although this participant did not meet the inclusion criteria of giving birth in the selected institution, the researcher and her Thesis Co-Supervisor decided that this birthing experience would be relevant to validate themes, categories, and a taxonomy which the researcher had previously identified through analysis of the data. Secondary participants were asked to confirm or refute the researchers finding, interpretations, and conceptualization of the data on one occasion using the Q-sort as recommended by Field and Morse (1985). Categories, such as types of communication patterns, were placed on 4" X 6" recipe cards and secondary participants were instructed to sort them into categories and to comment on the validity of the researchers interpretation. These two sessions were audio-recorded, however, comments were not utilized in the study. This procedure assisted the researcher to ascertain the secondary participants' thought processes as they validated information provided by primary participants and the researcher's interpretations of the data.

The consent of the participant and support person, if applicable, were obtained when the researcher and the participants met for the first antenatal interview. The researcher introduced herself, entered the setting, and presented the appropriate 'Participant Consent Form' (Appendices D & E), encouraging her to read it through and offering to discuss any part of the form or answer any questions. Following discussion, two copies of the form were signed by the participants and the researcher, and a copy was retained by each. The tape recorder and microphone were placed in a central position between the participants in the interview. The tape recorder was then turned on and the recording levels were adjusted giving the participants time to adjust to the taping of the interview. None of the participants objected to being audio recorded, although one indicated nervousness with the recording and stated she was more comfortable after approximately ten minutes. One other participant requested the tape recorder be turned off briefly to allow time to compose herself following a tearful account of her experience. The biographical data form was completed together by the participants and the researcher at the end of the first interview. At this time, the researcher clarified when and how to contact her via pager during the onset of labor, reinforced her role as 'participant observer' during childbirth, and how to contact her approximately 10 days postpartum.

At all times, the participants were left in control of contacting the researcher to arrange antenatal and postpartum interviews and to inform the researcher of the onset of their labors in order for the researcher to attend their births. It was determined that this arrangement would protect the confidentiality of their participation in the study and allow the women to opt out of participation if they had 'second thoughts' about continuing with the study. Ten of the 14 participants contacted the researcher at the appropriate time intervals: three participants 'forgot' to call at the onset of their labors and subsequent births and one telephoned to arrange an interview six weeks following a stillbirth.

Each participant was invited to select a pseudonym which would be assigned to the data from her interviews with an explanation of how the pseudonym would be utilized in the written report to ensure anonymity. The names chosen by the primary participants were Demi and John, Kari, Anna and Luke, Madeline and Joe, Carlynn, Jenny, Lauren, Julia, Mackenzie, Sandy and Dale, Mike and Allison, and Tracey and Doug. The two secondary participants selected the pseudonyms Emily and Diane.

Interviewing

Each informant agreed to participate in two to three interviews which were estimated to last approximately one hour and to have the researcher observe their births. It was found that at the end of one hour that several of the participants were in the midst of their stories and indicated their willingness to continue with the interview. Most participants needed approximately two hours to bring their stories to a natural conclusion and allowed the researcher adequate time to ask additional or clarifying questions.

Interviewing guides of descriptive, structural, and contrast questions (Spradley, 1979) had been prepared by the researcher for both the antenatal and postpartum interviews (Appendix F & Appendix G) and were placed in open view of the participants during the interviews. Descriptive questions were general and were asked to ascertain a sample of the participant's language without influence from the interviewer. Structural questions allowed the researcher to discover the depth of information about the concepts and categories within the informants knowledge. Contrast questions enabled the investigator to clearly understand the differences in the meanings of which the informants describe. Guiding questions allowed the researcher to obtain comprehensive information on the research questions while granting the participants flexibility to describe their experiences and perceptions (Field & Morse, 1985), however, most questions in the guides were usually covered by participants in the natural telling of their stories.

The antenatal interview enabled the researcher and the participants to establish a rapport and focused on the participants' expectations and anticipated involvement in decision making during childbirth. This interview was always initiated by the researcher with an invitation to the participant to "please tell me how your pregnancy has been thus far, just whatever comes to mind". The postpartum interview concentrated on the participants' perceptions of actual participation in decision making and communication with health care providers during childbirth. Participants were invited by the researcher to "please tell me about your labor and birth". As concepts and categories emerged from the data, subsequent interviews and questions became more focused and selective to obtain data relevant to the identified concepts as recommended by Field and Morse (1985). A third postpartum interview was requested from five of the participants for further clarification and validation of earlier data.

Participant Observation

Participant observation in the context of childbirth was intended to augment data and validate the interviews. However, if participant observation was not possible, research participants would not be excluded from the study. Whether or not childbirth had been observed data from the first and subsequent interviews were to be included in the study. As previously stated, although the researcher anticipated observing most participants during childbirth she was prevented access to the hospital setting. One labor and birth was observed by the researcher as the health care provider had consented to be observed while providing childbirth care in the hospital setting. Throughout the observation period, attention was focused on the participant's and health care provider's verbal and non-verbal behaviors associated with decision making. The level of participant observation was 'observer only' as suggested by Field and Morse (1985).

Field Notes and Research Journal

Field notes were written about each participant contact immediately exiting the interview and during the period of observation to record observations about verbal and non-verbal behavior, interactions regarding communication patterns and decision making in childbirth, characteristics of the setting, and interruptions or other factors noticed during the interview. Field notes supplemented interview data and were analyzed in conjunction with transcribed data. The researcher also kept a journal of subjective thoughts during the study to document events, thought processes, and ideas. The research journal was utilized as a method of 'bracketing' or setting aside the researcher's personal assumptions and biases. As the primary method of data collection was personal interviews, the use of self was regarded as an instrument. Lipson

(1991) refers to this interaction as reflexivity and it is intrinsic in qualitative research.

Data Analysis

Using primarily ethnographic interviews , the intent of the researcher was to gain a beginning description of women's experiences, expectations, and perceptions of decision making and communication with health care providers during childbirth. Interviews were audio-recorded, transcribed verbatim onto a personal computer, and then made into a hard copy. After initial transcription, the researcher replayed the taped interview to verify it against the hard copy of transcription. The transcription format included a half-page margin which enabled the researcher to code the data and write memos adjacent to the interview material. The transcripts were read and re-read by the researcher in an attempt to "dwell" and become intimate with the data (Field & Morse, 1985). Field notes and biographical information were analyzed to provide a holistic view of the research. Biographical data were analyzed and the characteristics of the participants are described in chapter four.

Each participant was identified by a pseudonym and unique color code; antenatal interviews were labeled 'A' and printed on pastel-colored paper, and postnatal interviews were labeled 'B', and photocopied onto corresponding neon-colored paper. Four copies of each transcript were made; one clean copy was given to the Thesis Co-Supervisor for her perusal and analysis, one copy was kept in a secure location, and the other 2 copies were utilized for the purpose of cutting and pasting into appropriate categories.

Analysis of the data began after the first interview and continued throughout the research process using the process of first level coding, pattern coding, and memoing (Miles & Huberman, 1984). Each phase of analysis reflected a movement from emic to etic so that the amount and degree of researcher interpretation increased. The researcher first engaged in first level coding after each interview was completed. The transcripts were read line by line and key words, descriptions, and incidents in the data were highlighted or underlined, and assigned code labels which were written in the margins. Key words, descriptions, or incidents were cut from the transcripts and placed in as many code files as possible to ensure full coverage. Rather than using preconceived code labels, the researcher tried to generate domains that were 'grounded' in the language of the participants (Spradley, 1979). The technique of constant comparison was utilized which compared the similarities and differences between the code labels (Field & Morse, 1985).

Examples of first level coding in this study are evident with the reoccurring key words "chatting" and "suggest" present in the data. Exemplars of chatting were assigned the code label "chatting", as it was described to be a type of communication reflected in data such as: "we had a nice girl chat"; "(physician) chatted to me"; "we (physician and I) just chatted in the hall a few times"; and "she (nurse) was very chatty when I first came in". The word "suggest" was noted frequently in the data and subsequently given the code label ""suggest option" as it was identified to be a type of communication generated by women's descriptions of: "(health care providers) suggested positions"; "she (nurse) suggested we just let him suck as much as he wants"; "she (nurse) always would suggest things"; and "(health care providers) had some good suggestions".

Next, pattern coding moved the data to an inferential conceptual level. Code labels were clustered into similar domains and concepts to formulate more of an over-riding meaning by asking "what is this?" and what is happening in this instance?". What emerged at this stage of analysis were patterns of meaning. Patterns of meaning reflect a process of making linkages between domains that encompass certain concepts and note "regularities that arouse the researcher's curiosity" (Miles, 1983, p.126).

As patterns reoccurred, a category evolved which captured the essence of the data segments. To follow through with the previous examples, "chatting" and "suggest options" were conceptualized to be a major content area with an inclusive pattern code of "Health Care Provider-Initiated Communication". It was conceptualized by the researcher that this data described a category of communication which was initiated by health care providers and facilitated client's participation in decision making during childbirth; thus the category, "Health Care Provider-Initiated Communication: Effective" was created.

Memoing, the last stage of the process, were records of the researchers' thoughts, ideas, and hunches while analyzing the data. Notes were written directly on the half page margin of the transcribed interviews which facilitated effective addition and refinement of codes and categories as the analysis progressed. Memos were also written on loose paper, dated, and accumulated during analysis of the data. They included directions to the researcher, summarizing memos, and visual representations of relationships between codes and categories. These memos provided conceptual insight into the creation of new codes, emerging concepts, hypotheses, and relationships. For example, the many descriptions of client communication patterns which occurred in the data as isolated concepts were collapsed in several stages of analysis. Each refinement of the category was traceable in the memos, enabling the researcher to track and verify coding through comparison of the data across participants.

Data from the transcripts were coded until saturation of each category was reached, that is until no new information was found (Field & Morse, 1985). This method of analysis proved to be an efficient and highly visual tool to check for saturation of categories, condensing and collapsing of categories, organization into and naming of themes, and easy location of indicators in the data to facilitate the reporting of the findings.

The researcher eventually developed an analytical outline of the conceptualization of categories which reflected the experiences of participants' decision making and communication with health care providers during childbirth. Discussion of each transcript and the emerging categories and concepts with the Thesis Co-Supervisor was the most effective tool in describing the analytical outline. The analytical outline included; participants anticipated roles in decision making, birth plans, uncertainty and the perceived effect of control on labor, health care-initiated communication which facilitated or hindered decision making, and decision making outcomes. This outline was confirmed as fitting to the experiences of two secondary participants, providing evidence that the descriptions are representative of the real world of human birthing experience.

Methodological Rigor

Many qualitative researchers (Field & Morse, 1985; Krefting, 1991; Sandelowski, 1986) agree that the standards for judging quantitative research, while relevant to the research using qualitative methods, require modification to be properly and fairly applied to naturalistic inquiry versus controlled settings. Researchers need to ensure methodological rigor in qualitative design to compliment the intrinsic assumptions within qualitative research (Krefting, 1991). Guba's (1981) model of trustworthiness is widely utilized (Sandelowski, 1986), and is comprised of four attributes: truth value, neutrality, consistency, and applicability. This model of trustworthiness will be utilized to guide the following discussion on methodological rigor in this study.

Truth value is a measure of credibility of the findings (Lincoln & Guba, 1985). Strategies to increase the truth value of the data obtained from participants in this study included: selecting participants based on their anticipated and actual experiences of the phenomenon of interest; asking the informants to use and explain their own definitions and terminology of communication and decision making; using open-ended questions and clarifying techniques for interviewing; and encouraging participants to tell their stories in the context of their own experiences. Inclusion of six labor support persons in the interviews enhanced the credibility of the findings as they prompted participant's to remember specific details of their birthing experiences. Extensive engagement and repeat interviews with participants provides the researcher with adequate time to establish a trusting relationship, resulting in the greater likelihood that participants felt comfortable in telling the truth. The establishment of a rapport also enables the researcher to learn the culture and detect any distortions in the data (Spradley, 1979). The researcher's use of the constant comparison method of data analysis strengthened truth value and confirmability of the data as this method allows codes and concepts to emerge, within and between participants.

Additional measures taken to enhance truth value in the study included seeking review of the researcher's interpretations of the data (Field & Morse, 1985) from participants, peers, and the Thesis Co-Supervisor. Review and validation of the findings by two secondary participants increased the researcher's confidence that the "researcher and the informants are viewing the data consistently" (Field & Morse, 1985, p.121). Hypothesized categories were validated by requesting another graduate student, who is a Nurse Clinician in a labor and birthing unit, to analyze the categories developed from the researcher's analysis. Participant, peer, and Thesis Co-Supervisor reviews resulted in general agreement on the fit of these data into the reported categories and conceptualizations.

Neutrality, the freedom from biases and assumptions in the research findings, were acknowledged and controlled as much as possible in the study by paying specific attention to the researcher as data collection instrument. The researcher evaluated and reported the degree of bias in conducting the sampling, data collection, and analysis (Lincoln & Guba, 1985), to prevent bias from infiltrating the findings. These measures included; keeping a journal from the beginning of the research process for the purpose of examining the researcher's thoughts, feelings, and decisions; and writing contextual field notes following each interview. Multiple methods of data collection, including; guided interviews, field notes, and participant observation, enhanced confirmability and grounded the results in reality. Audio-recording of interviews and verbatim transcription, verification of transcribed material for accuracy, and regular discussion with the Thesis Co-Supervisor were means of controlling potential researcher bias in the research findings.

Miles and Huberman (1984) suggest that the 'researcher as instrument' enhances trustworthiness in a study. As such, the interview conducted with the first participant, was used to test the interview guides, questions, and suitability of the biographical form. After this interview was completed, the researcher began analysis of the data. In subsequent interviews, the researcher's questions were more focused to check her observations from the data for congruence with the true experience of the participants. The attributes of the researcher include familiarity with the research questions and relevant health care literature, current labor and birth experience, and a keen interest in theoretical and conceptual knowledge.

In qualitative research, consistency of the data and analysis is evaluated on the basis of replicability of the sampling, data collection, and analysis.

Documentation is a primary tool to assist researchers in conducting consistent studies, described as an 'audit trail' (Lincoln & Guba, 1985), and in this study included: coding and recoding of the data; keeping code and decisional notes during analysis of the data; writing operational memos throughout the research process; evolving conceptual outlines of hypothesized relationships between categories of data; and thoroughly describing the methods of the study. Thorough documentation will enable another researcher, as auditor, to arrive at similar conclusions.

The purposes of qualitative research are not designed to ensure applicability or transferability to other settings or to childbearing women in general. Rather, the intent is to explore and describe the unknown basic categories and concepts in the data and to hypothesize relationships between these categories. The researcher presents findings in this study which are meaningful and applicable to the experiences of all participants, whether typical or atypical; findings which 'fit' the data from which they are derived (Sandelowski, 1986). The method and characteristics of the participants are described to provide readers with the necessary information to compare these findings to the experiences of other childbearing women during childbirth. Future research will be required to confirm the existence of these findings in the general population.

Ethical Considerations

The protection of human rights is essential for the conduct of research and was a careful consideration in this study. Safety measures to ensure informed consent and protect the anonymity of the participants and health care providers were built into the design and implemented in the research process. Ethical approval of the proposal for this study was received from the following: Faculty of Nursing Joint Ethics Review Committee, University of Alberta, on May

21, 1995; Investigational Review Committee at the selected institution on June 18, 1995, and from the Chief of Obstetrics and Gynecology at the selected institution on July 2, 1995.

Participant Informed Consent

All participants' contact with the researcher was entirely on a voluntary basis which reduced the risk of women perceiving or experiencing coercion to participate. Volunteers responded to the 'Study Notice' (Appendix A) and 'Letter of Information for Potential Participants' (Appendix B) which were available in the antenatal waiting rooms of four physicians who consented to participate. The notice and letter of information available to the volunteer participants were constructed in a simple, straight-forward, and factual manner in order to fully inform the respondents and to avoid coercion. Both documents were assessed to be below a Grade 8 reading level. Due to the lack of response with this method of recruitment, the researcher and her Thesis Co-Supervisors decided to place an advertisement, identical to the notice, in the classified section of a community paper. Respondents to the notice or advertisement were informed that a copy of the 'Letter of Information' (Appendix B) would be mailed to their address, and that after reviewing it, they could contact the researcher by phone if they were interested in participating. Only one respondent, who was sent a letter of information, did not contact the researcher to arrange an interview.

The researcher was prepared to give respondents the names and phone numbers for appropriate health care services to contact if such a need was warranted. As previously described in this chapter, seven respondents were referred to local midwifery collectives as they sought labor support for their imminent births, and one woman was given the name of an Antenatal Educator as she desired specific childbirth information.

The Consents for participation (Appendices D & E) were reviewed and discussed at the first meeting of the participant and the researcher. Participants were also assured that they could refuse to answer any questions or withdraw from the study at any time by notifying the researcher in person or by telephone. The planned use of interviews and observation of labor and birth were explained by the researcher, along with the procedures for guarding confidentiality of information which could potentially identify participants in the study. These procedures are described in full in the 'Participant Information Letter' and in the 'Participant Consent Form' (Appendices B & D). Following discussion, two copies of the consent were signed by participant, researcher, and labor support person, if applicable, and a copy retained by each.

Health Care Provider Informed Consent

Following ethical approval, the researcher met with 16 physicians who had privileges at the selected institution to discuss their potential participation in the study. Of the 16 physicians approached, two obstetricians and two general practitioners provided a letter of intent, consenting to participate in the study and indicating their willingness to display a 'Study Notice' (Appendix A) in their antenatal waiting rooms to access volunteers. The researcher also conducted three in-services with nursing staff to orientate them to the study and to discuss their potential participation. The 'Letter of Information for Health Care Providers' (Appendix K) and 'Health Care Provider Consent' (Appendix H) were reviewed which communicated the voluntary and confidential nature of participation, and the researcher reinforced that health care provider's employment status at the institution would not be jeopardized if they decided not to participate. These methods were implemented to prevent health care providers from experiencing or perceiving coercion to participate.

Given the number of health care providers involved in maternity care at the selected institution, the researcher utilized a method of 'negative consent' to exclude those who did not wish to participate in the study. All physicians, nurses, and interns / residents who would potentially provide maternity care to participants in the study were given a 'Letter of Information for Health Care Providers' (Appendix K) and a 'Health Care Provider Consent Form' (Appendix H). Health care providers who chose NOT to participate in the study were instructed to return the signed form to the researcher within a two week period in a self-addressed, stamped envelope. Both documents (Appendices H & K) included information pertaining to the voluntary nature of participation and the guarding of confidentiality, and were assessed to be below a Grade 12 reading level. Eighty one percent of the health care providers returned a form to the researcher indicating that they were not willing to participate in the study.

On the occasion that an observation was made, a 'Notice of Study' (Appendix I) was posted on the participant's birthing room door to inform staff that a researcher was present and that a study was in progress. 'Letters of Information' (Appendix K) and a 'Health Care Provider Consent' (Appendix J) form were available at the nursing station for staff who were providing care and potentially not aware of the study, although this scenario did not arise.

Confidentiality and Anonymity

Participants were assured that knowledge of their identity would be strictly limited to the researcher. Transcripts and audio-tapes distinguished each participant with a pseudonym, and health care providers were identified by their role of physician, nurse, resident, and intern. Participants' names, telephone numbers, and informed consents were placed in a locked file cabinet, separate from the transcripts and audio-tapes.

Participants were informed that all identifying data, including, names, telephone numbers, and consent forms will be destroyed at the completion of the study, and that raw data will be retained by the researcher for the mandatory seven years. Each participant was informed that disclosures of suspected child abuse would be reported to Child Welfare as required under the Child Welfare Act (1980), information which was also included in the 'Participant Consent Form' (Appendix D). Participants were informed that their words may be used in reports of the study but that no one would know that the data came from them.

Benefits versus Risks

During the initial telephone conversation with the interested volunteers, the researcher explained that there were no anticipated risks to participants who agree to take part in the study. The only direct benefit to participants is that women are given the opportunity to discuss their labor and birth experiences with an interested person. The researcher also emphasized that her role will not be in a supporting or coaching capacity.

It was the experience of this novice researcher that participants in this study readily shared their pregnancy and birth stories and were keen to help the researcher understand their experiences of participation in decision making and communication with their health care providers. Without exception the participants' responses to being interviewed were positive and ranged from comments such as "It was really fun to do" to the passionate, and tearful, "I really wanted to do this second interview, I needed to tell you how I felt at the time (of her loss) and hopefully others can benefit from it".

CHAPTER FOUR

FINDINGS

In this chapter the findings pertaining to women's perceptions of their experiences of communication and decision making with their health care providers during childbirth are described. To begin, the characteristics of the participants are provided. All potentially identifying features have been changed or omitted in order to maintain the participant's anonymity. Next, contextual factors, which include: the participant's anticipated roles in decision making; birth plans; communication patterns; and the perceptions of control and uncertainty will be described. Lastly, a description of the perceived outcomes of decision making and communication between participants and their health care providers during childbirth will be discussed.

Participant Characteristics

Characteristics of the participants are described to provide the reader with general information about the volunteers from whom the data were collected. A 'Biographical Data Form" (Appendix C) was completed at the first meeting with each participant. Aggregates of that data, along with data from field notes, have been developed and are presented in Table 4-1.

The main participants were twelve women who gave birth between October 1995 and November 1996. The age range of the participants was 25 to 39, including: four participants in the 25-29 age bracket; five participants aged 30-34; and three participants in the 35-39 age bracket. Five of the twelve women were expecting the birth of their first child and seven women reported having previous birth experience. All of the participants reported living in the metropolitan area of one city at the time of the study. Nine of the participants stated that their country of origin was Canada, two participants were originally from the United States, and one participant was born in the United Kingdom.

Table 4-1

PARTICIPANT CHARACTERISTICS

Characteristic	Distribution			
Age Range (Participant)	25-29 4	30-34 5	35-39 3	
Marital Status	Single 1	Married 11		
Education Status	High School 2	College Diploma 3	University Degree 4	Graduate Studies 3
Employment Status	Working In Home 1	Full-Time 8	Part-time 3	
Country of Origin	Canada 9	United States 2	United Kingdom 1	
Birth Experience	Primigravida 5	Multigravida 7		
Primary Maternity Care Provider	Family Physician 4	Obstetrician 6	Midwife 1	Midwife & Family Physician 1
Family Income	20-29,999 0	30-39,999 1	40-49,999 2	50-59,999 1
	60-69,999 2	70,000+ 2	not specified 4	
Prenatal Education Class	YES 11	NO 1		
Sources of Childbirth Information	Books 11	Friends 10	Family 7	Previous Births 4
	Videos 3	Movies 2	Midwife 2	Physician 2

All of the participants had either completed high school or had undertaken post high school education. The highest level of education achieved by the participants was reported as: High School (2), Post-Secondary College Diploma (3), University Undergraduate Degree (4), and, Graduate Degree (4). At the time of the study, one participant was pursing a graduate degree on a part-time basis.

Eleven of the twelve participants were married and one participant reported that she was single, and in a common-law relationship. Prior to the onset of maternity leave, employment status ranged from full-time status (3 participants), to working in the home (one participant), and included three participants who were employed on a part-time basis. Family income per annum was reported as: $30-39,999 (1); $40-49,999 (2); $50-59,999 (1); $60-69,999 (2); $70,000 + (2); while four participants did not specify their family income.

Choice of primary maternity care providers throughout the childbearing cycle was noted to have considerable variation among the participants, which was reported as: Obstetrician (6), Family physician (4); Midwife (1); and, Family physician and Midwife (1). Of the six participants who were attended by an obstetrician for their births, five of the participants were referred to an obstetrician by their family physicians at twenty weeks gestation. One participant, who chose a midwife for a home birth, initially saw an obstetrician for one antenatal visit early in her pregnancy.

All but one participant reported attending formal prenatal classes during the childbearing period; eight of the twelve participants attended prenatal education classes during this pregnancy, and three participants attended prenatal classes with a previous pregnancy. Other sources of childbirth education were reported as: literature (11); friends (10); family (7); previous birth experience (4); videos (3); movies (2); midwife (2); and, physician (2).

In addition to the 12 women, six husbands took part in the interviews and data representing their views have been included in the analysis. These couples include: Anna and Luke; Demi and John; Madeline and Joe; Sandy and Dale; Mike and Allison; and, Tracey and Doug.

Anticipated Roles in Decision Making

In the interviews, participants described their anticipated roles in the decision making process during childbirth. Although this question was not directly asked, women identified expectations for themselves, their partners, and health care professionals. These expectations of anticipated roles in decision making during labor and birth will now be described.

Expectations of Self

Participation in decision making was defined by women in the study as "having a say" in decisions concerning their labors and births. All of the women commented that they expected to participate in decision making during childbirth, however, the anticipated degree of participation varied from expecting to play minor roles to major roles. Each and every participant expected to be given information from their health care providers during labor and birth in the forms of choices, explanations, suggestions, options, and guidance. The participants commented that their expectations of their decision making roles were contingent on their: previous birth experiences; knowledge levels; and, personal philosophies of childbirth.

Previous Birth Experiences

While the primiparous women in the study did not have personal childbirth experiences on which to base their decision making expectations, several multiparious women in the study, Kari, Anna, Jenny, Lauren, Julia, and

Mackenzie, commented that they were "prepared" to take a more active role in decision making in their impending births than they had in their previous births. These women stated that because of their previous experiences, they were prepared to make their plans and decisions "known" to their care providers, rather than be told what to do. Kari shared her experience in which she "didn't really have a say" in making decisions related to her care during her first birth. "This time", however, she is prepared to "stand on the bed and yell at them (care providers) and tell them this is what I want and this is what I mean (laughs)" if they appear not to be listening (A, line 442-446).

Similarly, Jenny described her expectations of making her birthing "convictions" known:

> ...I think it's different for a first time mother as opposed to, you know, this is my third. And the first time, you pretty much let everybody tell you what to do and now I have my own convictions and I hope those are respected when I'm in there and so that'll be something that, you know, I hope it's not an extra stress (Jenny, A, line 720-733).

Jenny and Mackenzie also commented that they had received conflicting information from health care providers during their previous birth experiences which created "confusion". Because of these experiences, both participants were prepared to take more assertive roles in decision making in their upcoming births. Jenny illustrated this point:

> ...I think a lot of it is, you know you get a little bit pig headed, you know, because I was totally in trust with our first pregnancy when you don't know what to expect and you don't know what's going to go wrong and every time somebody told you something it's like, "okay", you know. I was fine doing that the first time... you know, one nurse is telling you one thing and the next one is telling me something different and I was getting very confused. And I felt I didn't maybe know enough and so then your second one you're better prepared and this time I felt even more prepared to um, stand up for what I believe I guess and what I want (A, 1342-1358)

In contrast, Carlynn and Lauren said that they "hoped" to make their wishes known to their care providers during childbirth, but noted they were not naturally assertive people. Although these women desired to have a say in decision making, they were unsure of their abilities to confront their health care providers. Carlynn commented: "And it's a short enough time and a fragile enough time that we should be able to make demands and our wishes known. Hopefully, I will be assertive. But, it's not my natural self" (A, line 534-536).

Knowledge

Women in the study identified that knowledge was a critical factor in decision making during childbirth. Participants described how they acquired information throughout their pregnancies from a variety of sources in order to gain knowledge and to prepare for their births. These sources of information were described in the previous section.

Several women commented that they felt "vulnerable" and "anxious" when their pregnancies were initially confirmed; feelings which originated from their inadequate knowledge levels and the uncertainties associated with pregnancy, labor, and birth. Participants expressed feeling more "prepared" for their births after seeking information, which enhanced their knowledge levels and confidence in their abilities to be involved in decision making. Dale and Tracey commented:

> I've never felt so vulnerable as entering into parenthood and going through childbirth. Just having no intuition whatsoever of what to expect and just, I felt so incredibly naive (Dale, B, line 140-145) ...And I found that once we had done a little bit of research into it, and talked to people it made a huge difference. It was really helpful (Dale, B, line 167-169).

> At first we really didn't know what to expect and we were scared (laughs). You know, things we didn't even begin to expect were going to happen so we wanted to find out as much as we possibly could. We learned a

> lot, you know, and now we have an idea of what to expect and what we can do to give it our best shot (Tracey, A, line 335-341).

In addition to acquiring knowledge during pregnancy, all of the women in the study expected to receive information from their health care providers during childbirth in order to make choices and decisions. Expectations were based on information received from their health care providers in the forms of "guidance", "explanations", "suggestions", "options", and "choices".

Kari, Tracey, Allison, and Lauren commented that they expected to take minor roles in decision making during their labors and births. These participants stated they were going to "keep an open mind" during childbirth and were depending on guidance from their care providers to help them make the best decisions. Kari said that she would like to have "some control in making decisions", however she was "relying on the hospital staff to help" her during childbirth (A, line 622-623).

Tracey stated that she had some "background knowledge", but expected "lot's of suggestions from care providers" throughout her labor and birth (A, line 147-149). Lauren believed that she had some knowledge, "but I need them (care providers) to give me ideas and information... I'll probably use a little bit of everything" (A, line 1043-1048).

Allison noted her expectations:

> And my expectations are to be proactive and involved. And I know, of course there's different options available to me and there will be suggestions and that... And I'm going in with an open mind, saying I'll give it my best shot and I'll do as much as I can" (A, line 1130-1136).

In contrast, Jenny, Anna, Madeline, Julia, Sandy, Carlynn, Mackenzie, and Demi anticipated taking major rather than minor roles in decision making during childbirth. Jenny wanted to have "freedom" to make her own choices (A, line 991). Anna, Madeline, Julia, and Sandy expected to consider information which was provided by their health care professionals and then decide what was "best" for them (Anna, A, line 1572-1574; Madeline, A, line 617; Julia, A, line 661; Sandy, B, line 187).

Carlynn and Mackenzie described the importance of receiving information from their health care providers which would enable them to make informed choices:

> I think sometimes there's false decision making when people feel like they're given a choice when there's really not. And they're kind of railroaded. First of all you need to have the adequate knowledge to make the decision. Um, so you have to be given the options and understand what's happening to you. And if you don't, you need to be given an explanation of what's happening to you. You need to know what's going to happen as a result of actions, so you can decide whether, do I want this or do I want the alternative, which is nothing. Then what might happen? So I guess knowledge is the key. To be able to make a choice and have it have an effect (Carlynn, B, line 1577-1596).

> It's like you need them to tell you and explain what's happening but you, you know, also need to know enough about what you want to do. Them telling you stuff is important but I also want to make up my own decisions of what's going to work for me... (Mackenzie, A, line 303-307).

Demi was unique; she adopted a "wait and see how it goes" attitude regarding her imminent birth and did not expect any guidance from health care providers. Demi stated that she expected to be completely responsible for making her own decisions during childbirth:

> I don't think that they (care providers) give you alternatives at the hospital. I don't know if it's an ethical thing, but you have to ask for everything and they told us that in the prenatal classes. The nurses aren't allowed to suggest things to you I don't think. We knew it was all going to be up to us (B, line 96-100).

Personal Philosophy of Birth

Several women in the study noted that their personal philosophies of childbirth influenced their anticipated decision making roles, and commented that they expected to achieve birthing experiences which would fulfill their own needs. Mackenzie described birth as "an inner type of thing" (A, line 1685-1686). Similarly, Lauren and Anna noted the importance of having their philosophies of birth respected by their health care providers:

> I know there's certain guidelines that you have to follow at a hospital. You know, there's certain things that they (health care providers) do, that they have to do. But, there's some things where there's, where the mother, where the parents, well I'm the one giving birth. It's my baby. It's my body, so I should be able to say what I want and don't want (Lauren, A, line 1129-1142).

> "...we are the ones having the baby and these are our children and it's our birth experience and if (health care providers) are not comfortable with that, then it's (their) problem and not ours. It's not harming the baby, and it's not harming our children, it's not getting in the way of medical care that I need or the baby may need (Anna, A, line 652-656).

Madeline, Jenny, Sandy and Dale described their attitudes which regarded birth as a "natural" process and did not view themselves as "sick". Their expectations of participating in decision making emerged from their fears of unnecessary medical interventions during childbirth. Jenny commented:

> Ya, you know, it's like, this is supposed to be a natural thing and we're making it very unnatural. I kind of feel like it's my body, I know what's going on with it, like I feel a lot. I think I know about myself and just sometimes think that when it comes to childbirth especially if you're sort of put in a big realm of, you know, all babies come out the same and blah, blah, blah. Whereas every woman's different. I feel like I should be listened to in the very least you know (Jenny, A, line 954-977).

Expectations of Health Care Professionals

Women in the study identified decision making roles for various health care professionals, including; physicians, midwives, and nurses. Their roles during childbirth were: to make critical medical decisions on behalf of the participants; facilitate birth plans; and provide support and guidance.

Role of the Physician

Women in the study expected their physicians to participate in two distinct roles during labor and birth. First, physicians were identified as having "expert" knowledge and were expected to have absolute responsibility for making critical medical decisions during labor and birth. Second, physicians were expected to facilitate the plans of birth.

Critical decision makers. It was commonly accepted by most women in the study that physicians possessed expert knowledge which would enable them to detect complications during childbirth. Because of this expert knowledge, several participants described that they had "trust" and "faith" in their physicians to make critical medical decisions in their best interests (Carlynn, A, line 369; Kari, A, line 152; Jenny, A, line 1247; Sandy, B, line 1065; Tracey, A, line 109; Allison, B, line 110; Anna, A, line 859):

> And we were very happy leaving that in our obstetrician's hands because, we came to have complete faith in him. So while we said that we didn't want an episiotomy, we told him, in the end you make the decision and you don't ask me... You get in there and you do it. But please consider our wishes and know what they are. Understand them. And let us know what you can respect and what not (Dale, B, line 620-636).

> Like I'm going to see what he (doctor) thinks. Whether he thinks that I really need it or not or whether he decides on the spot. I am prepared if he needs to do something. Like I really trust his judgment (Lauren, A, 542-545).

One participant, Mackenzie, commented that physicians receive respect in our society because of their expert knowledge:

> And people accept doctors as some kind of a, um, some kind of level above themselves, I suppose it's you know, a lot of respect but, it's far more weird than respect... (A, line 1897-1902). It's a kind of respect

> about their knowledge and position that triggers something in us and we feel like the child. No matter how old we are. We have revered them for so long, that they're more in a ministry (A, line 1942-1948).

Facilitator of birth plans. Expectations of health care workers in the role of facilitator during childbirth varied among participants in the study. Several participants expected their physicians to be present during labor and birth in order to facilitate their birth plans. Other participants did not express any expectations for continuous care, and commented that they would trust who ever was "attending".

Anna and Allison, expected their physicians to be present at their births and contracted these expectations with them in the antenatal period:

> But I was confident that she would come in and do the delivery even if she wasn't on-call... I asked her at the last visit how I could get in touch with her and she said, "you can call the office in the day time because I'll be here but otherwise there will be a note on the prenatal sheet to contact me" (Anna, A, line 521-523).

> That was a big issue with me, you now, in terms of, you know, vacation and what if it's in the middle of the night. She (doctor) guaranteed me that that's her job and that she would be there (Allison, B, line 1159-1164).

Several women reported that although they had discussed their birth plans with their physicians in the antenatal period, there was a "chance" that their physician would not be present at their births due to "on-call" schedules. Jenny, Tracey, Julia, and Sandy and Dale all expressed concerns with the idea of "not knowing" their on-call physicians and the uncertainties regarding their willingness to facilitate their plans of birth:

> ...the doctor's are in a group, like there's a group of six of them that cover the shifts and um, so the chance is you know, one in six that she's going to be working at that time (Jenny, A, line 254-259). Is the relationship that important if they're not even going to be there? (A, line 261-263).

> I talked to (doctor) about what we wanted, so that he knew our plans and stuff. He was fine with that which was great. The problem was, was that we didn't know he was going to be away that week-end and someone else was covering for him. That was a shock, you know, 'cause I really wanted him to be there. We were shocked and upset with that because we had talked about so many things about what we wanted and stuff (Tracey, B, line 100-108).

> (we asked) "How do we make our birth plan clear?" And he said, "You don't. You don't write it down. You don't attach it to your medical records", which is what we had been told in the prenatal class, to have our birth plan attached to our medical records. He says, "Don't. I'm going to be there. I know your plan. It's not necessary to have one there". I don't know if he was trying not to perturb the staff at the hospital but anyway, he said, "it's not necessary. I know what you want". And we had a great deal of faith in him that he was there. As it turned out he was going to be away for five days at a conference and so we had stood a very great risk of him not being there. So at that point we took him much more seriously and we wrote out a birth plan we were going to present to the nurse ourselves. (Dale, B, line 1051-1078).

In contrast, Carlynn and Demi did not expect continuity of care from their physicians, and stated that they would be comfortable with who ever was the attending physician. Carlynn noted that she was "familiar" with one member of her physician's on-call group:

> I haven't met the woman doctor, but I do know (other doctor). I had an infection after (first child) was born so I saw him and when I had my bleed in the summer (own doctor) was on holidays, so I saw him and I have met them. And then, I'm not, he had different mannerisms than (own doctor), but I'm sure he is competent. I don't have any real aversions or anything (A, line 358-363).

Demi commented that continuity of care was not important to her and that she would have "faith" in any physician who attended her birth:

> I have a lot of faith in my doctor's judgment and that she will make good decisions on my behalf. I knew that she wouldn't probably be there. You know you have your own doctor, but it's just who happens to be on call at the time. I guess I had faith in whoever the doctor was (Demi, B, line 105-109).

Support. Women in the study did not expect their physicians to participate in supportive roles during their labors. Lauren described her expectations: "You know, I don't expect him (physician) to be there the whole time, you know. He just comes in for the delivery and stuff" (A, line 594-599). Similarly, Carlynn and Jenny described their expectations:

> ...so the obstetrician really plays a small role during the labor and he'll just check in and things like that. I want him there (at the birth) in case something's wrong (Carlynn, A, line 368-370).

> ...and then you know you're supposed to be thanking your doctor for this great delivery and you're thinking, well you didn't really do a whole lot of work. You know he or she is the qualified one. But, ya, I find in the end you don't really look to your doctor to be the one to sort of be there for you (Jenny, A, line 1416-1425).

Role of the Midwife

Four of the participants in the study identified the importance of the midwives' roles during pregnancy, labor, and birth. Of the four women in the study, Madeline and Anna sought midwifery care throughout their pregnancies. Madeline decided to have a midwife-attended home birth and Anna had a midwife-attended hospital birth. Although Sandy and Mackenzie expressed interest in "hiring" a midwife, they did not pursue their interests due to financial reasons and the fact that midwives are not presently accessible in the health care delivery system.

All four women recognized that midwives possessed both expert knowledge and expertise in providing support during pregnancy and childbirth. Midwives were also expected to be collaborators in decision making, and provide continuity of care during the childbearing cycle.

Collaborative decision makers. Anna, Madeline, Sandy, and

Mackenzie identified the importance of collaborative decision making during pregnancy, labor, and birth. These women described collaborative decision making as a relationship of "sharing" between the woman and the midwife, involving trust, shared responsibility, and shared meaning through mutual understanding.

These participants commented that they perceived birth as a "natural" event rather than a "medical" procedure, and expressed concern that medical intervention was routinely provided in the hospital setting. Anna, Sandy and Dale, and Madeline believed that medical goals were often contrary to their personal goals and that a midwife would understand and accommodate their birthing needs.

Anna wanted her birth to be "low intervention" and her midwife "was really clear on that" (Anna, A, line 451-454). Understanding her wishes, the midwife was expected to work in partnership with Anna, and act as an "advocate" during labor and birth in the hospital setting (A, line 454).

Dale, Sandy's husband, described his "fear" of the medical profession possessing their pregnancy:

> And this kind of thing that the medical profession would possess your pregnancy, this was my big fear. It was just unacceptable to us. I see this as a natural condition not a medical condition. It's not an illness. Having a baby is such a natural experience. We were caught in a situation and I could imagine medical professionals saying, well then just have your baby at home. Why are you asking for our help? And it was something that we really seriously thought about. I wanted to have the baby at home. I wanted to have a midwife, however, I wanted access to medical intervention only if it was absolutely necessary. That was our priority (Dale, B, line 860-871).

Madeline, the only participant to have a home birth, was very suspicious of the dichotomy between hospital goals and her personal goals, and commented:

> I really don't see myself as pregnant and being sick. I see obstetricians and medical care as very important if you are ill or if something is wrong with the baby and need cesarean or even just an emergency. There's a reason that you have to do that. Plus on the other hand, being a health care provider myself I see the rushing of the obstetrician just as the baby is being born or a really quick episiotomy and all these procedures because they want to get out of there fast. I don't want my birth to be that way. It's just more of your birth experience. I don't want episiotomy if I can avoid it and I don't want the rushing out of the baby because they are on a short time frame. I wanted someone there who has the time to be there with you throughout the whole thing and will be there for the actual birth. So that was one of the things that made us decide, well you know, if we can't have what we want then we'll have the baby at home... (A, line 140-163). Whatever happens, it's your decision and your choice. They don't make you feel guilty. There's enough confidence that if something goes wrong we'll be told and make the decision to go to hospital and get the extra care that's needed (A, line 294-296).

Continuous care providers. Anna and Madeline identified that a fundamental role of the midwife as providing continuity of care during the childbearing cycle. These women believed that it was important to have alternative health care providers who were both "familiar" and "available" to provide support and guidance throughout their pregnancies, labors, births, and postpartum periods. Anna and Madeline described their expectations of midwives as continuous care providers:

> We have seen a midwife all along and I think she will play the main supportive role. Obviously she is going to come to the hospital with us as support. You know, she's not there to replace the nurses. With all the cut-backs that are happening there, I thought it would be good to have someone that we know and is going to be there, instead of understaffed and lot's of different people in. It might be hard to get that one-on-one sort of nursing that we had with our first two children (Anna, A, line 215-223)... but then it's going to be (midwife's) support during labor that is going to make the biggest difference (Anna, A, line 566-567).

> I guess I really wanted someone to be there who knew me well and who I could trust and would be there with me and (husband)... (Madeline, A, line 87-89). I wanted someone who has the time to be there with you through the whole thing and will be there for the actual birth. (Husband interrupts) And someone who has time afterwards too. (Madeline

> continues) Ya, and who can be there afterwards to help. And ultimately someone who I can trust, who knows me well and it seems more like it's a normal event in your life rather than some kind of sickness. Over time I just began to trust her and I trust her enough to feel really comfortable through this. With everything, she never makes the decision for you. She's just very supportive regardless of your decision (Madeline, A, line 430-446).

Madeline also described the expected role of her midwife in a hypothetical "worst case scenario", in which she or her baby encountered complications and they would have to go to the hospital. Madeline anticipated that her midwife will provide continuous support and act as an advocate with institutional health care professionals:

> I know that if we have to go to hospital then (midwife) will go with us and stay with us. That was one of my biggest concerns 'cause I didn't want to be abandoned there. So she'll (midwife) stay there and support us. She knows what we want, things like having the baby right away and (husband) close by my side. Sometimes they just whisk the baby away. She can speak up for me and (husband) (A, line 523-528).

Role of the Nurse

All of the women in the study were unable to articulate any decision making roles for nurses, however, they recognized that nurses would participate in supportive roles during childbirth. Several participants identified that nurses have expertise in assisting women during childbirth and anticipated they would provide guidance, relay information, and monitor their progress in labor. Anna, Carlynn, Allison, Jenny, Kari, Mackenzie, and Demi stated that nurses play important supportive roles during labor and that the amount of nursing care they expected to receive would be contingent on the "activity" level of the unit and the "attitudes" of the individual nurses.

Anna and Carlynn described the supportive roles of labor and delivery nurses as "critical". Anna commented that "the nurse makes the biggest difference as she's with me through the entire labor" (A, line 481-482). Carlynn commented that "nurses do all the work that goes on ahead of time", and noted that the guidance provided would "really make or break the experience" (A, line 229-232).

Jenny, Kari, and Mackenzie believed that the amount of support provided by nurses during childbirth would depend on how "busy" they were and the timing of the nursing shift change. These participants recognized that nurses were "hard working" professionals and often cared for several laboring women at the same time. Jenny said:

> I find in the end you don't really look to your doctor to be the one to sort of be there for you and uh, it's the nurses if they have time. That's when you hope that there's not a nursing change either. Get them in the middle of their shifts and that's the best time (Jenny, A, line 1422-1427).

Three participants anticipated that the individual personalities of labor and delivery nurses would determine the amount of support and guidance they provided during labor and birth. Jenny commented that the amount of support nurses are willing to provide "goes by what the nurses feel at the time" (A, line 1421-1422).

Allison stated that "a great labor and delivery nurse can make your experience so much more easy and rewarding" (A, line 961-963). She perceived that a "great" labor and delivery nurse would be someone who is "nurturing, caring, informative and has a personality that matches us" (Allison, A, 996-1000). Demi noted that "nurses can be helpful" depending on "how busy they are" and that "some (nurses) don't believe in drugs during labor and birth":

> "I think that some (nurses) don't want to offer it if they think you don't need it. I have heard that from other people that the nurses try to keep you from having anything and they make you wait a little bit longer to see how you do" (A, line 167-170).

Anna speculated that individual nurses may not be supportive of her birth plans which included the involvement of her husband, two children, midwife, and a family friend, and commented that she would like her midwife's "presence acknowledged and respected and not sort of put down" (A, line 211-212). Anna was of the opinion that a nurse who has "personal problems" and is unable to deal with her birth requests will be asked to "transfer our care to someone else", or "come in as infrequently as possible" (A, line 659-663).

Role of the Labor Support Person

Women in the study anticipated that their labor support people, or partners, would participate in varying degrees of "supportive" and "advocacy" roles during labor and birth. Supportive roles were identified by the women as their partner's being involved in coaching, offering encouragement, and providing comfort measures throughout labor and birth. The partner's role of an advocate was anticipated to be a liaison between women and health care providers and to participate in decision making during labor and birth.

Support. All of the women identified that their partner's would participate in supportive roles during labor and birth. Allison, Demi, Jenny, Julia, Kari, Madeline, Sandy, and Tracey stated that their partner's would be actively involved in providing massages, back rubs, offering encouragement, assisting with walking, holding hands, helping with breathing, and distraction techniques. Allison commented on the support she expected to receive from her partner during labor and birth:

> Mike is very strong and he knows what to expect, you know. Like, our prenatal classes helped, we are prepared, and I am comfortable with that because he learned all the comfort and support techniques that we would need and he is prepared to help me through it all (A, line 1050-1056).

Anna, Carlynn, Lauren, and Mackenzie stated that their partner's would provide support simply by virtue of their presence during childbirth. These women recognized their partners' limitations regarding activities during labor and birth as exemplified by Anna's comments:

> My husband is terrible when it comes to anything related to pain or needles or anything like that (laughs). He has passed out twice, so I think for him that as long as he has a camera to hold or that kind of thing to do, it takes his mind off it. And if he had to do breathing with me he would pass himself out (laughs) and we would have to do breathing with him. Seriously. I mean he went green when they came to take blood from me when I was in labor with our first. He does not do well in that kind of setting. So in that way I came to realize with the birth of our first two that I appreciate his presence there but he's not able to provide anything (A, line 319-329).

Advocate. Several women in the study expected that their partner's would act as advocates between them and their health care providers during childbirth. The role of advocate was identified as important by these women; they anticipated that they would be "working hard" and "focusing" on their birthing tasks, and might be unable to communicate their wishes to their health care providers. Partners as advocates were expected to be involved in collective decision making during childbirth and to uphold plans that the expectant couples had previously discussed in the antenatal period.

Anna, Jenny, Julia, Kari, Madeline, Allison, Sandy, and Tracey commented on the poignancy of their relationships with their partners. These women described how they had established meaningful "partnerships" with their significant others during pregnancy when they had discussed their concerns, fears, decisions, and plans associated with their impending births. They expected their partners to inform their health care providers during childbirth:

> We always make decisions as a couple. It's the way it's always been. We sit down and talk about our options and discuss them. And with the

> pregnancy it's the same. We are allies (laughs), you know, a real team. He won't hesitate to tell them (health care providers) what we need or want 'cause I may not be able to, you know, if I am into my labor and everything (Julia, A, line 332-337).

> There may be things that I forget or can't say at the time (Anna, A, line 439-440)... And then Luke knew too about the episiotomy and keeping it low intervention. So, I think that (midwife) will advocate for us to some degree but it's more of my husband's role to do that. Mine too, but my husband will willing to do that (Anna, A, line 451-455).

> My husband and I have done a lot of talking and I've said to him "Hey, if I'm in no position to be talking, you've got to be the one to say this". Because I think, you know, the nursing staff changes so much and things like that, he will be more verbal when the time comes. Just his third time around you both get stronger, being able to express yourselves, and not allowing decisions to be made for you. You know, I mean anyone can sit back and let everyone make your decisions but things that are really important to us will be definitely vocalized, you know, and we've both discussed this and my husband knows how strongly I feel about certain things (Jenny, A, line 1205-1223).

Birth Plans

In the interviews, participants were asked to describe how they would like their labors and births to transpire, from the onset of labor to the birth of their babies. All of the participants provided rich descriptions of how they wanted, or did not want, their childbirth experiences to evolve. As a result, three key categories emerged from the data and were considered important attributes of birth plans. These were identified as: preferences versus priority of childbirth; communicating childbirth preferences; and preferences for labor and birth.

Preferences Versus Priorities

Among the participants interviewed, the well-being of their babies was identified as the participants priority for labor and birth, and that the uncertainties associated with labor and birth required their preferences and plans to be flexible. It is important to note that all of the participants stated that they were willing to put aside their preferences and plans, and do whatever was recommended by their health care providers to protect the integrity of their unborn children. Health care providers were "trusted" experts; participants had "faith" that they would exercise good judgment and intervene only when the well-being of their babies were potentially compromised. Sandy and Dale provided an example in the data which illustrates this priority:

> ... the single premise that we had, was that we have a baby in utero that has a genetic potential. And we want to have that baby come out with as much of the genetic potential intact as possible. And that was our absolute, fundamental wish, our priority. We did not want any unnecessary interference, we wanted interference only under the direst medical intervention. And we were very happy leaving that in our obstetrician's hands because we have complete faith in him (Dale, B, line 612-623).

Anna and Tracey made a further distinction between their own needs, the needs of their babies, and the uncertainties of birthing:

> You know, you can sort of think in your mind that everything will be smooth and everything will be fine, but something may happen that makes things different. It would be really great if everything went smoothly. But sometimes it doesn't, and then the baby's needs comes way ahead of anything that we have in mind (Anna, A, line 280-284).

> The only thing is that if something went wrong or was wrong with the baby, then okay, you know, then I would be game for what ever was best, I would. I knew that (physician) would advise us to do what was safe. I trusted him to do that (Tracey, A, line 82-86).

Communicating Birth Preferences

The method in which participant's communicated their birthing preferences and plans to their health care providers varied among women in the study. Three of the twelve participants, Anna, Sandy, and Tracey developed formal, written birth plans in collaboration with their health care providers in the antenatal period: one sent her birth plan to the selected hospital to obtain authorization from the Labor and Delivery Unit Coordinator, and the other two gave copies of their birth plans to their physicians to include with their antenatal records. These participants described how they wanted to be involved in making decisions about aspects of childbirth and wanted their preferences to be available upon entering the hospital. Sandy related her motivation behind preparing a birth plan and making it available in her antenatal records: "We wanted them (health care providers) to please consider our wishes and know what they are. Understand them, and let us know what you can respect and what not" (Sandy, A, line 633-635).

Six of the participants discussed their birthing preferences with their primary health care providers during antenatal visits, and felt comfortable that they were "aware" of their birthing preferences. Allison said:

> Every time I went in we would talk about the plan and all that kind of stuff. It was pretty thorough. Mike and I also discussed what we wanted with (physician), in terms episiotomy and my thoughts on an epidural and any other pain medication. All that kind of stuff. He (physician) was aware of all that (Allison, B, line 1252-1259).

Three participants stated, that although they had preferences regarding certain aspects of childbirth, they did not discuss these preferences with their primary health care providers. Carlynn stated that she probably should discuss her preferences with her physician, but has failed to do so because of time restraints at the antenatal visits and her fears of disappointment from having unmet birth expectations:

> I haven't really discussed any plans with (physician) yet. I don't have the confidence, Is this the visit he's going to do an internal? or Is he just going to check the heart rate? And so you have this big hassle. It takes you an hour and a half to get there, it's a 5 minute visit. So, we haven't really discussed it and I probably should. I guess my plan is to make

> decisions as I go along. I kind of have the opinion that you can't really plan a lot until you know how it's going to go. I know what I would like, but if you have expectations then you end up really disappointed. I will keep an open mind A, line 350-363).

Childbirth Preferences

In the interviews, participant's expressed their preferences to the researcher about the following components of childbirth: place of birth; family support; labor intervention; labor behavior; birthing intervention; unexpected events; immediate post-birth; and, postpartum. These are described to provide the reader with information about whether the participants were "wanting", "not wanting", or "willing to modify" certain components of their birth plans. The main birth plan characteristics are presented in Table 4-2.

Eleven of the twelve participants preferred to birth at the hospital and one participant was planning a home birth. Madeline, planning a home birth, was willing to modify her plans and go to the hospital if there were any indications of fetal compromise: "I feel comfortable the birth will go better at home. There's enough confidence that if something goes wrong with the baby or me, we'll be told, and we'll make the decision to go to hospital and get the extra care that's needed (A, 293-296).

Family support during childbirth was a preference for all women in the study. Two of the participants, Mackenzie and Anna, also planned to have siblings attend their births, as long as their labors were progressing "smoothly". Both women were willing to change their plans if they encountered obstetrical problems, or if additional people in the birthing room were interfering with their health care providers' responsibilities: "If they (siblings) want to leave they can, and if they (siblings) need to leave, they need to do it without fussing, and quickly" (Anna, B, line 299-301).

Table 4-2

CHARACTERISTICS OF BIRTH PLAN

Participant #

Characteristic	1	2	3	4	5	6	7	8	9	10	11	12
Communicates Preferences to Care Provider	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Place of Birth	+	+	+	+	+	+	+	+	+	▨ +	+	+
Family Support	▨ +	+	+	+	+	+	+	+	▨ +	+	+	+
Labor Intervention	▨ -	▨ -	▨ +	▨ -	▨ -	▨ -	▨ -	▨ +	▨ -	▨ -	▨ -	▨ -
Birthing Intervention	▨ -	▨ -	▨ -	▨ -	▨ -	▨ -	▨ -	▨ -	▨ -	▨ -	▨ -	▨ -
Cesarean Birth	▨ +	N/A	▨ +	N/A	▨ +	N/A	▨ +	N/A	N/A	▨ +	▨ +	▨ +
Immediate Post-Birth	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +
Postpartum Care	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	▨ +	+	+

+	indicates **"wanting"** characteristic of birth plan
-	indicates **"not wanting"** characteristic of birth plan
N/A	indicates **"non-applicable"** characteristic of birth plan
□	indicates that the participant is **"willing to change"** characteristic of birth plan in childbirth, if necessary

Participants in the study expressed their preferences for labor intervention, which included the following procedures: intravenous therapy; perineal shave; enema; vaginal examinations, electronic fetal monitoring; medication; fetal scalp pH; amniotomy; and induction of labor. All but two of the participants reported that they did not want any type of intervention during their labors; the other two, Carlynn and Lauren, wanted medication to help them cope with labor discomfort. All women stated that they would modify their preferences to ensure the integrity of their babies.

Preferences regarding labor behaviors and immediate post-birth care were similar among the participants. Labor behaviors consisted of: alternative positions during labor; birth positions, such as side-lying and squatting; food and fluids; access to shower, tub, and toilet; camera and video-recorder; and music. Aspects of postpartum care were: family-centered programs; educational programs; rooming-in; early discharge; and home visits. Every participant in the study expressed a preference for certain behaviors in labor and for selected aspects of postpartum care; all stated they were willing to forego their preferences to ensure the baby's well-being:

Birthing intervention included the use of forceps, vacuum extraction, episiotomy, and stirrups. Participants were similar in their descriptions of not wanting any type of invasive or instrumental intervention during childbirth, however, they were inclined to trust their health care providers recommendations, if interventions were necessary to have a "healthy" baby:

> I don't want any part of forceps. But, having said that (sighs), if we come to a point in the delivery that I have to have forceps in order to have a healthy baby, I mean I will definitely do that. So I guess I will trust in the nurses and the doctor to advise that if that's totally necessary. But, it's going to have to be the very last ditch plan, 'cause I'm really adverse to those (Kari, A, line 93-101).

Seven of the participants indicated that in the event of a cesarean birth, they wanted their partner present in the operating theatre, to be awake during the procedure, and did not want the baby to be "taken away" until the operation was completed. All of the seven women reported that they were willing to modify their preferences if their baby's health was compromised. The other five participants did not identify any preferences for a potential cesarean section.

Preferences for the immediate post-birth period were desired by each participant in the study, which included: time of cord clamping; quiet environment; bonding; delayed administration of the Vitamin K injection; ophthalmic ointment administration; and immediate breast feeding. All but two participants were willing to modify their preferences for the post-birth period; Sandy and Tracey did not want ophthalmic ointment administered to their babies' eyes under any circumstances.

Communication Patterns

In this section, the interpersonal communications between childbirth participants, clients, and health care providers are described. Communication refers to the means of transferring verbal and nonverbal information within a social context. Within communication is found the observable manifestations of a relationship, therefore, the definition of communication involves both conveying information and influencing another throughout the process of the relationship.

During the interviews, participants described their perceptions of how thoughts, ideas, and goals were shared or communicated throughout the childbearing period. Two classifications of communication patterns emerged from the data which were identified as effective and ineffective. Effective communication was perceived to facilitate and encourage a mutuality of sharing throughout participant-health care provider relationships, and consisted of: information-giving; explanation; reassurance; and attending. Ineffective communication hindered the formation of relationships and prevented participants from becoming mutual partners within the relationship, resigning them to be passive recipients of care. Types of ineffective communication were identified as: lack of information-giving; lack of explanation; lack of reassurance; and non-attending.

Each of the four types of communication and their perceived outcomes are presented, beginning with a definition and description. The perceived outcomes which characterize each type of communication are described and illustrated with indicators in the data. A summary table of these components is presented in Table 4-3.

Information-Giving and Lack of Information

Information-giving refers to the unsolicited conveyance of knowledge, facts, or news from health care providers to participants in the study. Six different ways in which information was presented to participants were: "introduced self"; instruction; suggestion, discussion, and orientation. In contrast, participants also identified ways in which information was not provided by their health care providers, which were identified as: no introduction; lack of instruction; opinion-giving; stereotyped information; and inaccurate information.

"Introduced Self"

Participants in the study said that it was important to know their health care professionals' names and their roles in the clinical setting. Participants noted that this information indicated an expression of friendliness, an openness to relate to them, and provided a beginning idea of what to expect from the professional person. Most importantly, introduction put a name to an otherwise "unfamiliar" face. Mackenzie recalled that she was informed who would be "delivering" her baby, as it was unlikely her physician would arrive in time for her birth:

> "...there was another woman there (in birthing room) who was taking charge. I wasn't sure who she was at first, but it was the other doctor... she introduced herself and said she was going to be delivering, but I can't remember her name. I wasn't worried then, you know" (B, line 692-698).

Mackenzie also stated that the "six staff" who attended her birth were well-known to her, as they had previously "introduced themselves" (B, line 481), and commented on the importance of knowing why each health care provider was present at her birth:

> Well, you know, there's something about giving birth and modesty, you know. It, modesty doesn't happen. Like, I couldn't care, you know. I could've had thirty five people in there and it wouldn't matter to me. As long as I knew they had a purpose. And each one of these people were significant in, in this birth process" (B, line 487-498).

Carlynn provided examples of care providers who shared meaningful introductions with her while she was anticipating an induction of labor:

> And the other thing that impressed me is that they (nurses) all introduced themselves to me. Like, even though they may have only come in one time or to do a specific task, you know, the half hour check or whatever. They all told me who they were and why they were there at that time. And uh, that was nice. And one, she recognized my name from the (neighborhood) area, and she had come and introduced herself to me... (B, line 628-640).

And,

> The, uh, the resident came in and introduced herself early in the evening, and said that she just wanted to let me know who she was in case she had to come in later in the evening, or if (doctor) didn't make it or something, that she would be delivering the baby. She just wanted to let me know who she was, which was also nice (B, line 647-655).

Table 4-3

HEALTH CARE PROVIDER-INITIATED COMMUNICATION

EFFECTIVE COMMUNICATION PATTERNS	INEFFECTIVE COMMUNICATION PATTERNS
INFORMATION-GIVING • **the unsolicited conveyance of knowledge, facts, or news**	**LACK OF INFORMATION** • **the lack of conveyance of knowledge, facts, or news**
"Introduced Self" • statement of the care provider's name and role in the clinical setting ***outcomes:*** friendliness, decreased anxiety, increased comfort, increased control	**No Introduction** • no statement of the care providers name and role in the clinical setting ***outcomes:*** anxiety, felt depersonalized
Instruction • "how-to" guidelines on actions to be taken by the participants ***outcomes:*** decreased anxiety, increased comfort, feelings of success, increased control, comfort	**Lack of Instruction** • insufficient "how-to" guidelines on actions to be taken by the participants ***outcomes:*** frustration, anxiety, decreased control, anger, concern
Suggestion • possible actions proposed by care providers as possibilities to consider ***outcomes:*** increased participation in decision making, increased comfort, increased control, increased knowledge, enabled choices to be made	**Opinion-giving** • conveyance of personal opinions of what participants should do in a given situation ***outcomes:*** uncertainty, anger, fear, frustration
Discussion • exploration and examination of issues pertaining to childbirth ***outcomes:*** increased knowledge, trust in health care provider, enhanced understanding, increased control	**Stereotyped Responses** • common and meaningless verbal statements ***outcomes:*** questioned relevance and meaning, excluded, decreased control, anxiety, anger, felt dismissed and pacified

Orientation • anticipatory information about likely, impending events during childbirth ***outcomes:*** decreased anxiety, increased control, ability to plan, enabled involvement in choices	**Inaccurate Information** • Information which is not complete or truthful ***outcomes:*** frustration, decreased trust in care provider, depersonalized, decreased motivation, deceived, increased anxiety, relied on senses and cues, suspect worst case scenario, concern

EFFECTIVE COMMUNICATION PATTERNS	INEFFECTIVE COMMUNICATION PATTERNS
EXPLANATION **• simplifying and clarifying the meaning and purpose of facts, knowledge, or news**	**LACK OF EXPLANATION** **• no simplification or clarification of the meaning and purpose of facts, knowledge, or news**
Rationale • the provision of reasons or principles behind a particular action or behavior ***outcomes:*** decreased anxiety, increased knowledge level, enhanced understanding, ability to choose	**"Policy" Statement** • the reasons provided for a particular action or behavior is mandatory compliance of an institutional policy ***outcomes:*** anger, decreased control, frustration
Procedures • further explication of actual procedures (how, who, when , where, what, and the associated risks) ***outcomes:*** decreased anxiety, increased control, comforting, enabled planning, make choices	**No Explanation of Procedures** • no explication of actual procedures ***outcomes:*** anger, decreased control, frustration, fear
Examination Results • non-technical explication of test results in relation to body function or fetal well-being ***outcomes:*** decreased anxiety, increased control, enhanced understanding, enabled planning	**No Explanation of Examination Results** • technical or no explication of test results in relation to body function or fetal well-being ***outcomes:*** felt depersonalized, decreased motivation, panic, presumed worst case scenario, uncertainty, decreased control

EFFECTIVE COMMUNICATION PATTERNS	INEFFECTIVE COMMUNICATION PATTERNS
REASSURANCE - **restoring courage and confidence**	**LACK OF REASSURANCE** - **no promotion of courage and confidence**
Confirmation - offering of support of mother and baby's status and progress though the stages of childbirth ***outcomes:*** comforting, affirming, decreased anxiety, felt included	**False Reassurance** - limited statements to defend care providers authority in health care setting ***outcomes:*** negated feelings, suspect worst case scenario, anger, frustration, patronized
Encouragement - providing verbal and non-verbal assistance and optimism of participants ideas and efforts ***outcomes:*** decreased anxiety, felt supported, increased confidence, felt accepted, felt cared for, increased control	**No Reassurance** - lack of assistance , optimism, and recognition of client's efforts ***outcomes:*** disappointment, frustration, fear, decreased control

EFFECTIVE COMMUNICATION PATTERNS	INEFFECTIVE COMMUNICATION PATTERNS
ATTENDING - **present in readiness for assistance and aligning physically and psychologically to participants**	**NON-ATTENDING** - **not available and/or willing to assist or align physically or psychologically to participants**
"Chatting" - sharing of information at an elemental level to establish rapport ***outcomes:*** calming effect, increased confidence, increased comfort	**Lack of Dialogue** - unable or not willing to engage in friendly dialogue or establish rapport ***outcomes:*** negated feelings, anxiety, insignificant, freakish
Listening - recognizing what participants are saying with their words and expressing in non-verbal behavior ***outcomes:*** conveyed interest and respect, increased confidence	**Not listening** - no recognition of what participants are saying with their words and expressing in non-verbal behavior ***outcomes:*** decreased value in self, frustration, anger

Tone of Voice • slow and quiet manner of speech ***outcomes:*** calming effect, increased confidence in self and care provider	**"Rushing"** • abrupt and hasty participant-client interactions ***outcomes:*** decreased value in self, awkward, abandonment, impatient, appeared disorganized
Addressing Feelings and Concerns • recognizing and validating clients feelings and their meanings to increase the dimension of understanding ***outcomes:*** respected, felt legitimate, felt cared for, increased control	**Rejecting** • refusal to discuss feelings or subjects with participants and exclusion of participants in conversations among staff members in their presence ***outcomes:*** negated feelings, anxiety, insignificant, dismissed, pacified, felt excluded
Asking Preferences • inviting participants' childbirth plans and wishes ***outcomes:*** increased control, conveyed respect, increased choices, felt involved	**"Failure to Ask" Client** • no inquiry or acknowledgment of participant's plans or wishes ***outcomes:*** depersonalized, patronized, awkward, anger, fostered dependency, anxiety, insignificant, excluded
	Assumed Knowledge • take for granted that clients possess adequate knowledge regarding childbirth and newborn care ***outcomes:*** fear, doubted self competence
	"Told to" • commanded to perform specific task or action without rationale ***outcomes:*** decreased self worth, no control, no choice, frustration, anger

No Introduction

In contrast, participants described interactions with health care professionals who did not provide their names or their roles in the clinical setting, which made participants feel uncomfortable, angry, and anxious. Kari reports feeling "awkward" when she noticed an unfamiliar face among a group of health care providers in her room while she was laboring:

> "...she was wearing different stuff so she looked different from everyone else. I know that I kept looking at her and wondered who she was. Everyone else seemed to know her, But then I found out she was the anesthesiologist, and then I wondered why she was in my room. I started to feel nervous about what was happening" (B, line 182-187).

Tracey remembers feeling "angry", "frustrated", and "worried" with the sheer number of unfamiliar people present at her birth:

> So then the lights came on really bright and all these people came flying into the room, running around and getting stuff ready. Then this other guy came in and was whispering to the nurse, and umm, I just gave him a dirty look because I didn't know who he was and I didn't want him there. Then another guy came in. I remember his face and thought, who the hell is this? I mean, there were so many people in there and he was just one more guy... I remember asking if the baby was okay because there were so many people there, but no one said anything. I was worried that something was wrong. I was afraid something was wrong. (B, line 219-234).

Instruction

Instruction refers to information which provides clear guidelines on actions to be taken by the clients. Instruction or "how-to" information was taught by health care providers and included a variety of childbearing topics, such as: when to come to hospital, comfort strategies during labor, pushing techniques, postpartum care, and safety. Lauren and Carlynn recalled being very "nervous" about identifying the signs and symptoms of labor and were not certain when to travel to hospital. As both of their previous labors were induced and rapid, they were given the following instructions:

> So he (obstetrician) said, "well, when the cramps start getting pretty severe" and I said, "Well is my water going to break before I go to hospital or after?" And he said, "Well with some women it doesn't break till right at the last minute so don't wait for that". And he just kind of said when it gets really painful and you keep getting these cramps just go to hospital. He said not leave it too long... some women leave it too long... (Lauren, B, line 237-251).

> So he (obstetrician) instructed me that if I felt I was going into labor at all to come and so that night I was having, you know, not painful contraction but contractions every five minutes or so, so we decided we better go (Carlynn, B, line 53-58).

Participants in the study described how their nurses taught them and their labor support people how to utilize pain management techniques during labor. Lauren explains that she was in "terrible pain" and using nitrous oxide gas for the first time: "So I was breathing (nitrous oxide) all the time and the nurse was saying, 'just breathe when you're having a contraction'. I was going (short, quick breaths to demonstrate) trying to breathe in as much as I could, but I was getting dizzy breathing like that" (B, line 711-716). Mackenzie's husband was uncertain how he could assist his wife during labor and was taught how to administer lower back pressure to promote comfort:

> She (nurse) took her hand and she went down my spine like this and pressed, right into the small of my back. Whoa, you know, she reduced that pain fifty percent. Like, in a second. And then she took (husband's) hand with the next contraction and showed him how to do it...So every, every contraction (husband's) hand was there. And I tell you, this was great (B, line 328-345).

Instruction on breathing techniques was provided to Madeline during the birth of her baby. The midwife taught Madeline a particular breathing pattern in order to prevent perineal tearing as the baby's head emerged:

> And by the time it came to crowning I just wanted to get him out. I wasn't very good at it, you know and they said, "Stop. Take quick, short breaths and puff, puff, puff, breathe". It's hard to stop when you don't want to stop. Stop pushing and you have this incredible urge to keep pushing, but in the end I did it, no tears or anything (B, line 737-743).

Allison and Anna described how they were given "thorough" instruction on how to care for themselves and their newborns:

> Before we left the hospital I had these nurses come in and they were very thorough, um, in going over everything you could imagine from my episiotomy care to his umbilical cord care to immunizations down the road, etcetera etcetera. Um, they just took a lot of time to go over that with us (Allison, B, line 1426-1433).

> This one nurse was really thorough... she was extremely thorough about what she was doing and she uh, went through this whole list of things to look out for, you know, and the hot-line number that you can call if you have problems (Anna, B, line 974-980).

Safety instructions were provided to Tracey, Madeline, and Anna during the postpartum period. Tracey recalls that her nurse provided the "number to call if we really need to ask questions or have any concerns, which was good to know" (A, line 279-280). Madeline, who gave birth at home, was taught how to assess and "massage her uterus" in order to prevent "excessive bleeding" from a potential postpartum hemorrhage (B, line 577). The midwife also gave Madeline a "little suction thing" and showed her what to do if her baby possibly "choked" on mucous when she was on her own (B, line 579). Anna remembers receiving safety instructions associated with her low blood pressure following the birth of her baby:

> So the next morning they took my blood pressure. She (nurse) said, "it's 80 over 40. Don't take a shower, don't take a sitz bath, just stay in bed and drink lots. Drink lot's of fluids" (B, line 717-718).

Lack of instruction

Lack of instruction was identified by several participants as an omission of information; their care providers did not provide them with clear guidelines on actions to be taken. This type of ineffective communication resulted in feelings of frustration, fear, and embarrassment, as illustrated in the following descriptions:

> I was sort of at the end of my rope by the time we got admitted into the hospital. We had been there the previous night, about 9 o'clock the night before. I thought they were going to admit us into the hospital. We had been [told] to come when the contractions are 5 minutes apart and hurting, and they were. I was one and a half centimeters dilated and they said, "Maybe you should go home". Woah! They already told us to come when you are 5 minutes apart, so when do we come back? There was nobody around who was helping us. They said that they would come back in 20 minutes and it ended up we were sitting there for about 3 hours and nobody came back. Finally we went home. I was frustrated because I didn't know when I was supposed to go back. We came back when I basically couldn't take it anymore at home. And then I was afraid they were going to send us home again (Demi, B, line 152-194).

> I went 2 weeks over, so I had to go to the hospital and get induced. Um, I was supposed to be at the hospital at 7 o'clock in the morning and they said they were going to insert some tablets. Well, I felt really stupid because I thought that it was actually going to be, pop a pill and have a glass of water. The doctor shook his head and said, "No, insert". I thought, oh right, you aren't going to put those tablets in my ear (Kari, B, line 29-35).

Dale commented on the frustration he felt with their health provider's lack of instruction while Sandy was birthing their baby:

> The birth was so prolonged... it was one and a half hours at least and we were sort of floundering in the dark and getting more and more depressed. I knew from prenatal class there are tons of positions we should be trying because it wasn't making any progress. But you know, I'm going crazy and I'm not able to think right away what they are. I thought that maybe Sandy's pelvic diameter was too small or something. Maybe that's what was hanging it up. I knew that if she squatted she could maybe increase that diameter. The nurse wasn't giving us any of this. So eventually we asked and she said that Sandy can get down and

> squat, but the communication was terrible. She gave very few instructions of what Sandy should do and Sandy was missing it completely.

Suggestion

Suggestions were clearly identified as an important way of relaying information from health care professionals to the participants in the study. Participants claimed that suggestions from their health care providers were given as alternative actions or possibilities to consider, allowing them to make informed choices. Anna, who was postmature and reluctant to have an induction of labor, received suggestions from both her physician and midwife, and said:

> ...I saw the doctor again four days later or something and she said, um, "well, this week we'll have to induce you (Pitocin or ARM), either induce you tomorrow, or if not, we can do another Ultrasound, Doppler, and non-stress on Wednesday" (B, line 172-177)... So she (midwife) said, "Well, you can try this blue and black kohosh, or whatever, which is an herbal preparation that's been around for years and years" and she said that, "if you're ready to go (into labor), it might just tip you over into labor" (B, line 201-207).

Mackenzie and Allison were opposed to taking medications during childbirth because of possible effects on the baby. They were given suggestions by their nurses for alternative methods of relief that would not potentially harm their babies. Mackenzie's nurse suggested using nitrous oxide gas: "And she had said, 'would you like to try some gas?', and I says, 'no, no, no, no. I don't want the baby groggy and this and that'. The nurse provided an explanation which further clarified her suggestion, by stating, 'the gas doesn't cross the placenta' (B, line 257-261).

Mike and Allison commented that they were also given suggestions for pain relief by their physician during labor:

> Allison absolutely did not want to use any type of pain killers and it got to the point where the pain was so excruciating that she couldn't handle it. The doctor said, "why don't we try something that will take the edge off", um, and Allison... (Allison interjects) was fighting it. (Mike continues) Well I don't know if you were fighting it, but you know it gave us alternatives to consider... (B, line 1196-1210).

Health care providers also suggested a variety of birthing positions during labor. Madeline and Anna recalled various birthing positions that were suggested as alternatives:

> The pain was so bad it seemed like I didn't know what would help... (Madeline, B, line 1042). She'd (midwife) say, "Well, why don't we try the bathtub... would you like to try the bed... we can try another position or the birthing stool". She would never tell me what to do. It was always up to me. They would always offer sort of another suggestion, that maybe we can try something else. Maybe that'll help with your pushing or your contractions. It was always up to me (Madeline, B, line 1948-1055).

> ...when I was walking, you know I'd feel a lot in my back... and then when they got a lot stronger after they broke my water, she said about trying to lie on my side and then she would lift up my leg, the top leg and that made a big difference (Anna, B, line 579-587).

Julia remembers feeling "overwhelmed" after the birth of her stillborn son and "didn't know what to do" (B, line 194-295). Her physician offered the suggestions of "holding him and seeing him anytime"; suggestions that Julia had not thought about and greatly "appreciated" (B, line 298).

Opinion-Giving

Participants in the study provided rich descriptions of their care providers presenting their personal opinions of what participants should do, rather than offering suggestions as possibilities for them to consider. This way of communicating was perceived as "bothersome", and negated the value of the participants as partners in decision making. Sandy and Dale recalled that their care providers during labor and birth adhered to their own opinions of what should be done, and their personal choices :

> She (nurse) seemed to regard our birth plan with a degree of impatience. And in the end she accommodated it pretty much all the way. For instance, when we asked not to have the baby bathed etcetera, she made her feelings known through her expressions all around you. (Sandy interjects) Even little things. Like I was wearing my nightgown and she really thought I should change into a hospital gown and I just didn't want to be bothered with anything anymore, let alone get changed. One little item of clothing, and she just kept, it seemed to me, she just seemed to repeatedly say, "Wouldn't you be more comfortable?", and here, here it is, right here. And I was just like, don't bother me with this. I've got other things on my mind (B, line 1144-1182).

And,

> This is something that the nurse in the delivery room was not on our side about, and we had to argue, or argue with her about it. She eventually took the baby and put it on Sandy's bare belly (Dale, B, line 972-978)... She (nurse) didn't agree that it was important. She felt it was more important to observe the baby in the incubator, sort of heat lamp over top. She wanted the baby to stay there for a very, very long time. Now I thought if the baby was against Sandy's chest with a blanket over her, a swaddling blanket, that would pretty much be the same thing. But her concern was the baby be under the heat lamp and just observation. She didn't even want the baby to go to Sandy's breast and we had to argue about that. We did get our way in the end, only for one breast, and then she said, "That's it", and took the baby again (B, line 1022-1056).

Jenny remembered her experience with health care providers, who had newborn-feeding opinions which differed from her own:

> They said to feed the baby right now, but I didn't want to be doing that. I wanted her (newborn daughter) to get on her own schedule, but they wanted her to be on a 4 hour schedule. The nurses would be coming in and they'd say, "Oh, it's been 4 hours and she hasn't nursed yet". I guess they wanted her to go a maximum of 4 hours, but she would sometimes only go 2 hours and she'd nurse, and then the next time it might be 5 hours. So I was letting her set her own schedule, whereas I think they were trying to be on a certain schedule. I even had one nurse that would come in and try to wake her up. They have their own philosophy I think. So I thought that was hard, because you get that extra pressure to feed the baby now. And that was difficult, but I knew as soon as we got home we could do our own thing anyway (B, line 898-919).

Discussion

Discussion refers to the exploration and examination of matters pertaining to childbirth; health care providers and participants actively engage in exchanging information and ideas regarding childbirth issues. Allison, Jenny, and Madeline identified that discussion was an important way of receiving and sharing information. Allison described how she developed her birth plan and shared information through discussions with her physician:

> Every time I went in you know, we'd (doctor and I) discuss the plan and when to call him and that kind of stuff and, you know it was pretty thorough. We also talked about medicine and I had discussed with him, in terms of an episiotomy or um, my thoughts on an epidural and other pain medications and all that kind of stuff... (A, line 1145-1153).

Jenny and her physician engaged in discussions during the antenatal period, which resulted in referrals to literary resources and also alleviated Jenny's concerns about episiotomy:

> We discussed quite early in the pregnancy what our expectations were. I'm not sure if it was just the doctor's I had or because they had more time, but right off the start any questions I had or any feelings I wanted to share, she always discussed them with me, and encouraged me to read lot's more about different procedures and things (A, line 336-345).

> We hadn't discussed this at our last visit, you know the episiotomy and things like that, so when we talked about it at the next visit, she just let me know that was a common ground. That they, all six of the doctors in the office let you try and deliver first, and then they would do the episiotomy only if they felt the need... that was really helpful (B, line 459-470).

Madeline commented how discussions with her midwife provided her with unbiased information in order to make decisions, in contrast to conversations she previously had with another health care provider:

> Our midwife is very much like, here is the information and here are your options, and you can decide what you want. Like my doctor wanted me to have an ultrasound and (midwife) never said yes you should, or no you shouldn't. She just said that these are the reasons why you might want to have one at this time and this is what it will show you. Then on the other hand, these are the things that it won't show you. She just discusses the information and never makes the decision for you (A, line 436-446).

Stereotyped Information

Stereotyped information refers to the conveyance of common, seemingly meaningless, verbal statements. It was a perception among participants in the study that health care providers who gave stereotyped information or responses, assumed that all childbearing women were the same. Like many of the participants, Dale recalled how he had received vague and general responses to his specific questions and concerns:

> We had gone to see a physician in the city who was recommended to us, but he had a very different approach... His approach was more that he would take care of the medical side of the pregnancy and any questions or problems that arose, that were physiological in nature, were didn't need to concern ourselves with. He would possess the pregnancy and take care of it, all we had to do was be proud parents. I didn't appreciate when I had questions that were, you know, physiological in nature, whatever, he would try and dismiss them and give me very cold-meal kinds of general answers. We somewhat resented being told, well, we're going to paint you with the same brush as absolutely everybody else... (B, line 230-251).

Demi described that she was keen to discuss aspects of her birth plan with her physician, when she received the following standard response:

> ...in this book, it mentioned that you should have a birthing plan before you go into the hospital, and it said to make all the decisions beforehand. I asked the doctor about a birth plan and he said that it wasn't really a very good idea and that you should sort of go in with an open mind. He said to make all the decisions once you're in there, because it's not going to be what you expect (B, line 38-47).

Carlynn remembered that the postpartum teaching she received was not specific to her learning needs, rather, her health care providers appeared to be "reading a script": "I didn't find the information they imparted really useful at all. You know, it was stuff I either already knew or it was irrelevant at the time" (B, line 1119-1123). Mackenzie and Tracey recalled similar experiences:

> I told the nurse that I knew all about nutrition, but she harped on and on, all about nutrition. An um, I'm aiding (baby) along at the breast and the nurse says, "Uh, don't do that. People, they don't do that anymore. That's the old fashioned way of doing it. Just give her the breast and she'll find it". Well I felt like saying, no she won't, because we've been trying that for the last 26 hours and it doesn't work. I know! (Mackenzie, B, line 1341-1353).

> I hate to say, but it was a waste of time! I was really, really tired and all I wanted to do was sleep, and she (nurse) gave me her spiel about blood tests and jaundice and all this stuff. I didn't ask for it and I didn't understand most of it. And it didn't matter anyway because she (baby) was not jaundiced! I think she did it more for herself, so she could tick it off her checklist or something bizarre like that (Tracey, B, line 1566-1582).

Julia noted that she was given a typical response following a very atypical and unexpected event; the diagnosis of an intrauterine death:

> Well, they told me that they were going to give me an IV with medication in it to start my labor and that I should have an epidural. I told them that I didn't want any kind of medication. Then the resident doctor said that this medication wouldn't harm the baby. I was so confused. On one hand, I thought our baby was dead so what did it matter. I mean, you know, what did he mean about the medication not affecting the baby? (B, line 180-189).

Orientation

Orientation consists of presenting specific information about probable future events or processes during childbirth. Several participants identified orientation as an integral way of receiving preparatory information from health care providers; this information was perceived to decrease anxieties associated with uncertainty, include participants in making future choices, and enabled participants to plan their activities.

Carlynn, Lauren, Madeline, and Kari were given information regarding likely events such as the onset of labor and the anticipated time of birth. This information eased the anxiety associated with uncertainty; "waiting" for labor to begin and "not knowing" when it will end. Carlynn noted that her last week of pregnancy was very "hard" as her cervix was already four centimeters dilated, yet she was not experiencing signs and symptoms of labor. During her last prenatal visit Carlynn recalled the physician telling her: "the doctor said, 'I usually don't do this but I give you an eighty percent chance you're going to have this baby within the next couple of days'" (B, line 1535-1540). Similarly, Lauren was nervous about when her labor would commence and was "relieved" to hear her physician say, "that this labor was going to be shorter and soon" (A, line 411-412).

While in labor, Carlynn, Lauren, and Madeline were told by their care providers their probable times of births. This information was perceived by the participants as "comforting" as they knew that their births were imminent. Carlynn's nurse told her: "'You'll probably go (birth) fast once they break your water'" (B, line 179-180). Lauren also recalled that when examined in labor, she was oriented to the fact that "...this baby's coming right away'" (B, line 200-202).

Similarly, Madeline was getting discouraged about the length of second stage labor and remembered how her midwife oriented her to the probable time of birth:

> ...they would keep telling me that first time labor should be this long and you know you should push for one to two hours on an average..." (B, 1333-1336). They would give me that information and then like that

> would help me in that. Because had that not been the case, then I would have decided to go to the hospital" (B, line 1377-1382).

Inaccurate Information

Some of the women identified that the information they received from their health care providers during childbirth was not complete or truthful; information which made them feel "deceived" and "wary" of their health care professionals. For example, Dale and Sandy were informed by their childbirth educator in prenatal class:

> You don't have a choice (regarding newborn eye drops). This is (a) provincial regulation and what you want doesn't matter... and it was adamant at every level that we asked for that information. We were told that this is out of your hands. You are really going to have a battle on your hands if you try to prevent your baby (from) having the drops in the eyes. We were led to believe that this was going to be the battle of the province, you know. But it turned out to be nothing (Dale, B, line 740-777).

Julia and Kari shared their emotional experiences in which they suspected that the well-being of their babies was compromised; they had to rely on their own senses to establish the truth, as they received information from their health care providers which was incomplete and untruthful:

> I seemed to have a lot of attention but they told me it was because I was the only one in labor... I noticed the heart rate monitor away from me twice, and the first time I said, "you know, what is that machine and why can't I see it?". No one answered and I lost my train of thought, I think because someone walked into the room... The second time was when the anesthetist was there and then the doctor came in, and he got me to try a bunch of different positions. He asked me to try a few positions like lie on my left side and then lie on my right side. And that's when I realized that everybody was looking at the monitor. And everybody, there must have been 4 other people in there. I said loudly; "I want to see the heart beat monitor", and I just started crying. When they turned the monitor around and I had a contraction, the heart rate went down to 60. I freaked out. I was really crying and upset because I knew what the numbers meant... I wish they would have told me. I felt like I had caught them with their hands in the cookie jar and they were trying to pull the

> wool over my eyes and not tell me the truth. I would have felt better had I known, although I may still have freaked out too. I feel like I would rather have known what was going on rather than catching them at it (Kari, B, line 224-274).

> They put me on the monitor to listen to the baby's heart beat, but we couldn't hear it. The nurse was almost frantic trying to find the heart beat, and then she left and came back with another nurse. The new nurse didn't say anything either. My husband finally asked the nurse how the baby was, and she said that they would know more after an ultrasound. She looked very nervous and kept chattering (B, line 128-136)... Well (starts to cry), I knew that something was terribly wrong. I had such a sick feeling and nobody was trying to reassure me or anything. Everyone was talking to each other, but they didn't say anything to us. I really felt like I was sitting in a corner, watching the whole thing. Then they took me down to ultrasound in a wheelchair and they wouldn't allow (husband) to stay with me in the room. He was really upset and shouting that he didn't want to leave me, but they told him, um, it was policy. He was furious. The horrible thing is that when the nurse, the ultrasound nurse, was looking at the baby, everything looked okay I thought. It was hard to see what she was looking at through the screen and I kept saying that I thought the baby looked okay, but she didn't say a word. Then the specialist, came in and talked to the ultrasound nurse. Then, Oh God, (doctor) turned on the lights and told me that there was no heartbeat, and um, that he was sorry but my baby was dead... I just didn't believe him (B, line 125-165).

Explanation and Lack of Explanation

Explanation is a type of communication that simplifies and clarifies the meaning of information given to participants in the study. It further elucidates the purpose for specific behaviors and events in the childbirth setting. Explanation went beyond information-giving in that the caregivers provided the rationales behind the events the participants were experiencing. Participants identified that explanation was an important communication strategy utilized by their health care providers as it further enhanced their understanding of information which was provided to them, and included: explanation of rationales, explanation of procedures, and explanation of examination results.

Inadequate explanations from health care providers were also identified by participants in the study, which prevented them from understanding the rationales and reasons behind the events they were experiencing, and included: "policy" rationale, no explanation of procedures, and no explanation of examination results.

Rationale

The explanation of a rationale refers to the voluntary conveyance of reasons or principles for a particular action or behavior. Participants identified that an explanation of reasons "why" assisted them to understand the action or behavior more clearly, often appeasing anxieties associated with "not knowing".

Dale and Sandy commented on the importance of understanding both the principles and rationales behind events in their pregnancy. Dale described how they were "never left in the dark" by their physician:

> ...the obstetrician that we went with constantly talked to us the whole time, told us what, you know, what was going on. What he was doing. Why he was doing it. If he ordered a test, exactly why he ordered it. If he felt there was a fear, or if he was just trying to cover all the bases... and that was very, very important to us. I don't know if that's the case for most couples, but for us, we do fall into that end of the spectrum (Dale, B, line 281-293).

Lauren and Carlynn, described how their health care providers offered reasons why they could not have pain medication as they had requested. Both participants remembered that their explanations were "comforting":

> I was screaming for pain medication. Ya, ya, ya. The one nurse was older, she was very comforting. She was saying that, "you know, the baby's going to come very soon. We don't have time to give you any painkillers. You're not going to feel the effects of them anyway", and she was good to tell me that (Lauren, B, line 497-504). (Doctor) was saying, "...listen Lauren if i give you some morphine now, you're not going to feel it until after the baby's born. The baby's almost out". He guided me down and I felt the top of her head. And I couldn't believe that it's head was right out. So again I put my hand on there and I felt her whole

> head... 'cause I didn't realize that she was almost born (Lauren, B, line 411-427).
>
> I wasn't in pain until I was in my, you know, second stage of labor and she was coming and then it's too late... (Doctor) said, "there isn't anything we can give you at this point because she (baby) is coming". And I appreciated that, it was very comforting to know why I couldn't have anything at that time, you know, I was in severe pain" (Carlynn, B, line 842-852).

Jenny and Carlynn were given explanations for their unusual behaviors following their births. Jenny remembered feeling "embarrassed" after the birth of her baby because her "whole body was shaking all over the place" (B, line 397-398). Her physician made her feel "really comfortable" when he explained the reasons why she was trembling, which was "normal after birth, like the after shock of birth because the muscles are working so hard" (B, 392-394). Similarly, Carlynn recollected:

> Well right afterwards I felt, like I was just shaky. Like it was, my hands and stuff were just (trembling noises). I remember shaking after (son) was born but not as bad and I didn't know why. They told me it was because I was shocky and I had lost quite a bit of blood. More than normal... I really felt relieved to know that (B, line 231-238).

Madeline's midwife explained how the principles of gravity would assist the descent of the baby if she alternated body positions. Madeline recalled, "they (midwives) would always offer sort of another suggestion, that maybe if we try something else, maybe that'll help with your pushing or your contractions, you know, with gravity working with you and stuff" (B, line 1078-1082).

Anna was concerned about how frequently her baby was breast feeding and was considering supplemental bottle feeds. The nurse explained the rationale behind breast feeding 'on demand', and Anna recalled that she "appreciated" knowing the physiology behind this type of breast feeding:

> ...and this older nurse, who had lot's of experience just said, "no, let her

> suck as much as she wants and it'll bring in the milk faster. You need the sucking action to stimulate the breast to make milk" (B, line 910-915).

"Policy" Rationale

Participants in the study commented that they were not informed of the reasons or principles behind a particular action or behavior, rather the only explanation they were given was that it was an institutional "policy". For example, Carlynn recalled that she was not given a reason why she could not have her intravenous discontinued following the uneventful birth of her daughter:

> They said that they wouldn't take it (IV) out until I got to the floor, which I thought was a strange rule to have. They said that was a rule... that was their protocol. That was it, and they left it in. They took it out at the end of the shift , so it was about 7 o'clock (B, line 361-385).

Tracey and Lauren were not informed of the reason why their newborns were taken to the nursery soon after their births. Tracey remembers feeling "worried " because of the lack of explanation:

> So then they (nurses) said they were going to take the baby to the nursery for some checks and things. I asked if she could stay with us for a while, but they said that was not possible, that it was their policy. I was a little worried that something was wrong with her... (B, line 261-264).

Lauren, was uncertain why her baby was taken to the nursery, and commented: "...and they took her to the nursery because that's their policy. She was there for about four hours and they had to check her, or something, don't they?" (B, line 930-933).

Sandy and Julia were upset to learn that their spouses were forbidden to attend and observe their ultrasound scans, and recalled feeling "angry" when no rationale was provided:

> ...when we were told that we should get an ultrasound at 18 weeks, I phoned to make the appointment and requested that Dale could come in with me. I had to call literally every clinic in the city and was told by each that that was not permissible, it was their policy. They just said that we can't make an exception because if we let him in, then we're going to have to let every father in and we just aren't equipped to handle that, but every clinic gave those same answers (B, line 398-410).

> Then they took me down to the ultrasound in a wheelchair and they wouldn't allow my husband to stay with me in the room. He was really upset and shouting that he didn't want to leave me, but they told him, um, it was a policy that he could not stay... he was really furious (Julia, B, line 147-152).

Procedures

This manner of communicating refers to providing clients with specific knowledge about anticipated procedures, which includes: what the client will be doing; what will be done to them by the attending professional; the sequence of events in the procedure; time involved; equipment, instruments, and medication used; and possible consequences. Procedural explanations were identified as an integral part of overall communication by several participants in the study, especially since many of the procedures were considered invasive. The procedures associated with childbirth that were experienced by participants in this study were: amniotomy, cesarean section, epidural anesthesia, episiotomy, fetal monitoring, intravenous, induction of labor, placental doppler studies, suction, temperature regulation, ultrasound, and vaginal examinations.

Anna experienced numerous procedures throughout her pregnancy which originated with the assistance of fertility medication. At five gestational months she was informed by her physician that her baby was not growing in accordance to gestational age. Her physician explained which investigational procedures were warranted, what the procedures entailed, and the potential consequences. Anna recalled:

> (Doctor) said, "Well, you have grown some but not as much as you should have". So he talked about what what's going to happen and we went through a month of being assessed and tested, you know if this baby was intrauterine growth retarded, IUGR, or what's going on. He was really good and explained the tests and stuff, so I had ultrasounds and assessments (placenta) at the (hospital) and they really couldn't find anything wrong with the baby or whatever. It is just going to be a long, skinny baby I guess (A, line 46-52)

The sequence of events and time factors associated with the procedures were also fully explained by Anna's physician, and ultimately understood, as evident when Anna stated:

> ...Last week I had the ultrasound again just to see what the placenta was doing 'cause they say it's about a grade three, which I guess is as old as it can get. So they were worried about the baby getting enough blood, so they were doing studies of how the blood flows through the cord (A, line 107-111)... that seemed to be okay. They will do another one in a week and a half if I haven't delivered (A, line 115-116)... (During labor) the monitoring I don't mind and I see in this case they probably will need to be pretty vigilant with monitoring just to see how the blood flow is going and how the baby is reacting (A, 376-379).

Demi and Kari were given explanations regarding epidural anesthesia by their attending anesthetists. Demi, who was initially reluctant to have an epidural because "it seemed kind of dangerous" (B, line 131-133), was given information which explained the risk factors and benefits associated with the procedure:

> "But the more we learned about it, we realized that everybody does it and that there are risks associated with it, but they are pretty slim. The benefits out-weigh the risks"... the anesthesiologist explained everything to us again and made us sign the consent form and made sure that we understood it" (B, line 109-111).

Kari was offered the choice to be "awake or asleep" during her impending cesarean section (B, line 269). She based her decision to have an epidural on the explanation provided by the anesthetist, paying particular attention to information regarding time factors, medications used, and possible outcomes. It was important for Kari to see her baby immediately after birth and also she did not want her baby sedated (field notes). An explanation of the cesarean section was given to Kari before and during surgery; Kari remembered:

> ...she (anesthetist) was phenomenal. She talked to me about everything and really made me feel comfortable because I didn't expect any of this. She was outstanding (B, line 479-481)... And once I got into the surgery room or whatever you call it. God there were towels and masks and things everywhere. But I could hear her. The anesthetist was really good and stuck right by my head and gave me a blow by blow description of what was going on and what would happen next. She said, "Okay, now they are doing this, now they are checking out your baby and they are doing the Apgar scores and everything looks okay". She really talked me through it all (B, line 470-475).

Carlynn and Julia were given explanations pertaining to their required involvement, the sequence of events, equipment and medication used, and consequences prior to an induction of labor which involved intravenous medication. Julia recalled: "... the head nurse came in and spoke with us. She was very kind and told us what was going to happen. She explained about the medication to start the contractions" (B, line 191-193). Similarly, Carlynn understood the procedure she was about to experience, and stated

> 'Cause he (physician) checked me before they started the drip and I was still only four to five (cervical dilatation). I hadn't done anything (B, line 208-210)... the nurse um, explained the protocol to me and the risk to the baby and you know, their uh, that they observe the baby for four hours in the nursery afterwards and what the incidents are, problems and that type of thing (B, line 314-320)... And they had the monitor on because you know I was being induced, had the medication running (B, line 776-778).

Madeline was given specific knowledge by her midwife regarding perineal massage to prevent the need for an episiotomy or perineal tearing. Madeline described being aware of the procedure, what was involved, and possible outcomes:

> And she (midwife) kept putting a warm cloth there too which was really nice. Very comforting. And then she poured out oil... poured it on his head too. And she'd pour it on the perineum and she'd put her fingers in and she was stretching me... And she kept stretching and stretching and so, you know, I never had a single tear after all that pushing or anything (B, line 708-727).

Dale and Mike noted how their health care providers adequately explained the procedures associated with temperature regulation of the newborn. Both participants were aware of the sequence of events, equipment used to maintain thermoregulation, and possible consequences of cold stress to the newborn.

> ...and then she took the baby and was explaining all the things that she was doing. Put it under the heat lamp for one thing. She thought it was very cold and it was (B, line 982-987)... her concern was that the baby be under the heat lamp long enough that his temperature go up (Dale, B, line 1028-1030).

> Ya, so then they stuck him under the thing (radiant heater) for probably about a good forty-five minutes and I was watching him the whole time. They couldn't get his temperature up. They finally got it up and then they had to give him a bath and then his temperature dropped down again after the bath. And then they had to warm him up again because it was too low and that's not good for the baby (Mike, B, line 602-622).

No Explanation of Procedures

This method of communicating refers to the lack of adequate explanations surrounding procedures. Participants were uncertain of events associated with childbirth procedures, including: what they will be doing; what will be done to them by the attending professional; the sequence of events in the procedure; time involved; equipment, instruments, and medication used; and possible outcomes.

Several women described feeling "unsure" and "concerned" when their health care providers were constantly monitoring their babies' heart rates during childbirth. Sandy said:

> ...there's no explanation about what this was, or that, or on the one side we're recording contractions, on the other side the fetal heart. There was no description of what was going on . (Sandy interjects) I was feeling very, uh, kind of useless actually. Every time she put the monitor on again, I guess because I didn't know anything about it, I thought there must be something wrong. She's constantly checking it to make sure the baby is okay, so I think that there must be a problem. And that, I think, must have had an effect on me cause I distinctly remember thinking that there was something wrong and that's why she kept doing that (B, line 1405-1421).

Mike and John commented that they were not given adequate explanations about procedures and equipment used at their births, and remembered feeling really" frightened" at the time:

> They said that they were going to help the baby out but they didn't say what was going to happen. They got this suction this up and they were pulling. It was basically pulling him by his head and then the nurse was elbowing Allison in the stomach to get more pressure behind her (Mike, B, line 329-334).

> I was over there and I said, "she's not breathing". They suctioned her and they were rolling her around and hitting her feet trying to get her to breathe. Then the pediatrician came running in. I don't know what he did but she started breathing right after, and then he left (John, B, line 417-422).

Lauren noted that she was not given any information from her health care providers about how they were going to keep her baby warm:

> I thought she felt a bit cold, so they put her under a lamp in the same room there. I felt foolish 'cause I remember thinking that they've left her over there and she's all uncovered... And so I said to (husband) to go over and check, because the lady's left her there and she hasn't got any clothes on (B, line 850).

Demi recalled that explanations pertaining to hospital admission procedures were omitted, which added to her anxiety about hospitalization. The first time Demi and John presented to the hospital in labor they were sent home without adequate instructions as to when she should return; Demi described her experience of returning to the hospital

> ...we waited about 15 or 20 minutes, or was it longer? But then we didn't know when we were going to get admitted and I thought they were going to put me in an assessment room again, or send us home and go through that again.

Demi was also unsure what was involved with having an epidural anesthetic; she was surprised to discover, at the last minute, that an intravenous line and urinary catheter had to be established prior to the procedure: "I had no idea. The nurse just brought everything out and said that I have to have this if we're going to have the epidural..." (B, 139-141)

Results of Examinations

Several of the participants in this study described how their health care providers offered 'thorough" explanations of examination results. This information explained what the test measured in relation to body function or fetal well-being. Explanations were provided in non-technical language and free of medical jargon, and terms were defined in everyday language or in analogies that the clients were able to understand. This manner of explanation was recognized as enabling clients to clearly understand their results and subsequent implications.

Lauren, Carlynn, Jenny, Mackenzie, and Allison described how their health care providers clearly explained the results of internal examinations performed during labor (Carlynn, B, line 131; Jenny, B, line 638; Mackenzie, B, line 465; Allison, B, line 283). For example, Lauren recalled that she was aware of her labor progress: "(doctor) said I was ten centimeters dilated and the opening was big enough for the baby to pass through" (B, line 331-332).

Kari commented how her care provider resolved her feelings of embarrassment with a simple test and explanation:

> So, I put on another pair of panties and had some breakfast and they felt wet again. I thought, Oh, no. I have suffered the last indignity. I have lost control of my bladder (laughs) (B, line 41-44)... they admitted me and took me to my room and I told them about my bladder. I wanted to let them know because I was really embarrassed. And they said, "actually it may or may not be bladder, it could be amniotic fluid. Sometimes there is a little hole in the sac and fluid leaks out just a little bit. It is easily confused with urine because of the color". So they had a little pH strip tester-looking-thing and they showed me how to test it and said, "yes, it was indeed amniotic fluid. You are going to have your baby today" (B, line 48-58).

Anna and Jenny received information on the status of their babies immediately after birth. This information was spontaneously provided and thoroughly explained by their health care providers. Anna and her family were given the results of the Apgar score and the gestational age examination. A nurse explained the criteria for the Apgar test and how the baby scored in each category (field notes). As well, a nursery nurse "took the time" to explain to Anna's sons the "different reflexes" their new baby sister elicited to determine gestational age (B, line 835).

Jenny's physician carefully explained the findings of her baby's initial assessment; information which was "significant" to Jenny as her baby was postmature and had passed meconium in utero. Jenny said that this information alleviated her anxiety that "something" may be wrong:

> ...he (doctor) was really good. Um, you know he just, he explained everything, because she didn't have a lot of the vernix on her. He just explained because she was overdue. That she was a little bit dry and he wanted to make sure her lungs were totally clear, and they were thankfully (B, line 415-426; field notes).

No Explanation of Examination Results

Several of the participants in the study commented that their health care providers did not offer explanations following various examinations, or that explanations which were provided, were full of technical, medical jargon that they did not understand. This way of communicating was described as impairing the participant's comprehension of their examination results and subsequent implications.

Jenny and Carlynn were not given any information after they had investigations completed for possible placental malformations. Both participants commented that they had to make assumptions about the results, rather than have this information offered to them:

> This other doctor goes, "Oh by the way, they found this previa", and I didn't even know what a previa was. And he basically said to look for any bleeding and things like that. But I didn't even really understand what it was so when I came home I started reading about it and I thought that it sounds a bit more serious than what he sort of made it out to be. And then talking to other people, they were telling me that I should be off work and . I was worried... (Jenny, B, line 604-621).

> ...I didn't ask, but I think it might of had to do with the bleed I had earlier. Um, they just said that it looked kind of funny. Like it, on the underside, I don't know if it was really attached firmly in the parts where I had bled. Like it might have been separated but I don't really know what they found(Carlynn, B, line 1040-1047).

Allison commented that she felt humiliated when she thought that her membranes had ruptured spontaneously during labor, and was not offered an explanation from her care provider:

> I thought my water broke before it actually did. We called her (nurse) in, you know, we didn't know what was going on. And, she came in and said "Ya", kind of like that. And I told her that I thought my water broke. I was still in bed at that point, you know, it was after being hooked up to the monitor for like an hour And she kind of took this little piece of paper

> thing to do a wetness test or something like that . And she basically said , "No, it looks like you wet the bed", and she left the room. I felt like a moron... (B, line 763-783).

Carlynn noted that she was given the results of her baby's blood tests in jargon that she, a health care provider, was unable to understand: "They wanted to take her bilirubin because she was a little bit jaundiced already... It was 208 or something and all she did was give me the figure expecting that I would know what it meant" (B, line 1133-1145).

Reassurance and Lack of Reassurance

Reassurance refers to a way of communication that restored courage or confidence in participants in the study. It is a method of communication which acknowledges unspoken fears and anxieties associated with the uncertainties of childbirth, and facilitates clients' expressions of their true feelings. Reassurance was identified as an effective type of communication by participants and was achieved in two ways; confirmation, and encouragement. In contrast, participants provided rich descriptions of interactions with their health are providers which were perceived as ineffective, which included; false reassurance, and no reassurance.

Confirmation

This type of communication involves the ways in which health care providers offered support that participants in the study were "on course"; that is, both mother and baby were progressing successfully and safely through the stages of childbirth. Confirmation was identified as an important way of receiving reassurance by participants in the study, and was perceived as "comforting" and "affirming".

Madeline, Lauren, and Anna were reassured by their health care providers that they were progressing appropriately throughout labor.

Reassurance was not perceived by the participants as judgmental, but rather confirmed that progress was as it should be. Madeline, who is a registered nurse, described her concerns of laboring "properly":

> When in your mind you might think, ya, I'm doing this (labor) right. 'Cause I have the information, but it's having someone remind you that yes, you are doing this right. You know, 'cause it's the first time you've done it. You've read it in the books or seen someone else do it, but when it's yourself, just having someone remind you that that was the case was comforting (B, line 1357-1366).

Anna and Lauren were told that they were "progressing well" throughout the first stage of labor. Anna remembered her physician saying, "you just keep walking if you want, and you know, things are fine... and progressing well" (Anna, B, line 751-756). Lauren described that she was "frightened" at the speed with which her labor was progressing, and noted that her nurse was "really good", as she was "reassuring me the whole time that everything was okay, and the baby was going to be out right away, and it was all going to be over within a few minutes" (B, line 1041-1047).

Madeline and Lauren were given feedback by their care providers that confirmed 'what' they were feeling is what they 'ought' to be feeling. Madeline remembers "holding back" her pushing attempts because of the "terrible pain" and "had no idea it was going to be like that":

> But then (midwife) said to me, 'yes, that is, that is the worst pain. It is a terrible pressure' and like they (midwives) kind of confirmed that, you know, it is there and as soon as you get the baby out, then, and that's what I kept thinking. The baby comes out and I get rid of this terrible pain (B, line 413-420).

Likewise, Lauren was "fighting" the strong urge to push her baby out as she was fearful she would lose control of her bowels. Her physician assured her: "Ya, it will feel like that, but you're not. Honest, you're not" (Lauren, B, line 480-482).

Anna, Lauren, and Madeline described the importance of being told that their babies' heart rates were safely within normal limits following auscultation with a fetal doptone (Anna, B, line 750-754: Lauren, B, line 736-743). Madeline recalled how critical it was to know that the baby was "okay" during labor:

> And they always told me when they checked (listened to fetal heart rate) the baby, if the baby was okay. That was what was really important, like I always wanted to know if the heart rate was okay and the baby was okay. And they would always check the baby and say, "ya, the baby's great". You know, I would wait to hear that (B, line 1367-1373).

False Reassurance

False reassurance was identified as an ineffective type of communication in which care providers offered limited statements to defend their authority in the health care setting. Seemingly reassuring statements, such as, "don't worry" and "everything is going to be okay", halted the flow of further information as to "how" or "why" the situation may be resolved. This type of communication was perceived by participants in the study as inappropriate; it served to reassure the health care provider and to "pacify" the participant.

Several participants provided descriptions of scenarios in which they were told, "don't worry". Jenny commented how the conversation was halted after seeking information about her low-lying placenta:

> I just needed to know what could happen and needed the reassurance that everything would be controlled for. And I didn't feel that, I didn't. She didn't scare me, but sort of sloughed it off as, you know, don't worry about it. And when you are put in the position you can't help but worry about it... And, again that was sort of a shortfall for me because I wanted to know what the options were (B, line 482-489).

Kari remembered that she felt anxious when she discovered, rather than was told, that her baby was distressed with the labor contractions:

> (nurse) came over and said. "You know, the baby's heart rate is going down a bit with the contractions... But don't get upset because getting upset is just going to make it worse. Everything is going to be okay", and she gave me a few pats on the hand (B, line 557-563).

Lauren noted how she was concerned when her baby's heart rate disappeared on the fetal heart monitor:

> ...they put the monitor on and it was reassuring to hear the heartbeat. And then at one point I guess the monitor moved and I couldn't hear it. So I was kind of worried about that. Like, where did the heart beat go? Like, what's happening and then she (nurse) came in. She said, "Don't worry", and moved it back on (B, line 645-649).

Several participants perceived that their care providers offered statements which defended their authority in hospital:

> I also asked about episiotomies and I said that I didn't want that. He got kind of upset and said, "Just leave the option open. We only do that if we have to do it, it's nothing to be scared of. A lot of people say that they don't want an episiotomy" (Demi, B, line 325-329).

> (while waiting for her physician to arrive to attend her imminent birth) ...a few of them (nurses) talked about their qualifications... like one nurse said, "Don't worry about it. I've been doing this for 22 years, you know" (Mackenzie, B, line 508-515).

> Her objective was really more to pacify, and I think, you know, it was very well intentioned. Rather than dealing with the issue and saying, this is black and white and this is the information, she got defensive in her statements... I found her defensive actually. Anything that we would mention, it seemed like her reaction was , "Oh don't get uptight about that or you know, I'm not trying to tell you". It was always this defensive reaction (Sandy, B, line 1134-1141)

> ...Tracey was kneeling on the floor in the shower and screaming that the baby was coming. I mean she was really serious. The nurse came running in and tried to get Tracey to relax. She kept telling Tracey to settle down and not to worry because she had been doing this for a long time (Doug, B, line 201-206).

Encouragement

Encouragement refers to the acts of providing assistance, support, and increasing hope during childbirth. This method of reassurance showed responsivity and acceptance of the participants efforts, and was recognized as important by one participant in the study. Madeline described various ways that she was encouraged by her midwives during labor and birth, which included: verbal praise, nonverbal praise, and the use of mirrors.

Madeline commented on two scenarios during labor when she doubted her own capabilities and was given verbal encouragement and hope by her midwives :

> That's the thing. Like with (midwife), I started to lose it and felt that I can't do this anymore, I was too tired. They would say, "You can do this. You are doing this" (B, line 219-225). And they kept sort of saying that, you know, when it kept getting worse and worse and worse and worse and then they'd say, "yes you can do it" (B, line 801-805). But I think the biggest thing was, everybody kind of cheered me on. Everybody was just cheering. It was like a cheering section. You know they were all on the bed and pushing me and they were all, Mom, you can do this. And by then I was so tired, I thought I can't do this anymore... I leaned forward and pushed and I needed all of them(B, line 810-819).

And,

> I said, "Are you sure the baby's going to fit? I must have asked that ten times. And (midwife), you know, had put her fingers there and checked and said, "Oh, there's lots of room". You know, they were encouraging and that was the thing. They were very, everybody was very encouraging" (B, line 211-218).

Madeline also described the nonverbal support she was given during and after the birth of her son. During labor Madeline recalled: "And they held my hand when I was pushing. (Midwife) and (husband), I would squeeze their hands. They'd squeeze my hand and you know it was, it was all those things that they, that was how they communicated... it was incredible" (B, line 1956-

1961). Immediately following the birth, Madeline described how she received "powerful" non-verbal support: "And then they all came and gave me a big hug. It was very nice" (B, 610-611).

The use of mirrors were also identified as supportive, in that Madeline could visualize the progress she was making with every push:

> And they kept saying, "Well, you're there, we feel the baby's head and we think the baby has hair and they were kind of encouraging me. And then they had the mirrors. And we were looking at the mirror, trying to, you know, see the baby coming. At least see the hair once in a while and kind of encourage me that way (B, line 305-314).

No Reassurance

No-reassurance refers to the lack of assistance and optimism during childbirth. This approach did not convey responsivity or acceptance of the client's ideas and efforts, and was identified as ineffective by participants in the study. Carlynn commented on how she was not given any encouragement from her care providers when she walked in the hallways, trying to get established in labor, "every time she (nurse) saw me she would say, "You're still too happy (to be in labor) (B, line 655-657). Allison commented that her care provider was "professional, only to the point of being cold" (B, line 735-737), and reminisced about the lack of assistance and optimism she was given:

> Not warm. Not holding. Like, not touching me and saying you're doing a good job. Not giving me, you know, encouragement. It's kind of like her job was to make sure that I was okay and the baby part was okay, and that my blood pressure wasn't rising. And that basically that I was okay, but no more (B, line 743-751).

Julia and Dale commented on the lack of reassurance provided to them by their health care providers during childbirth:

> Well, um, (starts to cry), I knew that something was terribly wrong. I had

> such a sick feeling and nobody was trying to reassure me or anything. No one said anything, and I know that they felt bad for me (Julia, B, line 141-143).

> ...sometimes the heart rate would be 58, 76 and then it would go up, and I'm thinking is this normal? After this has gone on for a while, like I'm worried about this. I didn't want to vocalize it in front of Sandy because I knew Sandy was starting to panic that he's (baby) taking too long... And I didn't want to worry her but at the same time I really would have liked the nurse to say that this is okay, and I'm putting the heart monitor back every time, but the information I'm getting from it is saying that everything is normal (Dale, B, line 1363-1382).

Attending and Non-Attending

Attending is a method of communication in which health care providers paid attention and listened to the participants in the study. Care providers appeared ready to assist and aligned themselves physically and psychologically to their clients, conveying certain intensities of presence and "being with" their clients. Participants perceived that their care providers' nonverbal and verbal messages communicated "interest", "respect" and "acceptance". Several participants noted that attending skills were an important type of communication, which included: "chatting", listening, tone of voice, addressing feelings and concerns, and asking preferences.

In contrast, participants in the study provided rich descriptions of non-attending skills utilized by their health care providers, which included: lack of dialogue, not listening, "rushing", rejecting, "failure to ask", assumed knowledge, and "told to". These ineffective attending skills were perceived by participants to hinder communication during childbirth and enabled care providers to maintain their authority and control in the health care setting.

Chatting

Chatting refers to the sharing of information at an elementary level, and was identified as a meaningful method of establishing rapport between clients and health care providers. Subject matters were assorted and were not limited to childbirth issues. Several participants suggested that the importance of "chatting" with health care providers was to enable them to know their care givers at a personal level. For example, Mackenzie mentioned having a "nice girl chat" with several nurses during her labor which helped her to "know" her care providers (B, line 522). As well, Dale and Sandy stated that their obstetrician was "very much a talker"; he talked about "everything" which is why they felt comfortable "going to him" throughout the pregnancy (B, line 1331-1332).

Lauren described a "friendly" conversation with an individual she identified as being a medical resident who was "interested in her" as a person:

> ...I think there were a couple of residents in there. But the one was really nice. He chatted to me for a while afterwards. Um, and I think before he was talking to me before too. But he was, uh, he had come from another department in the hospital. I guess, and this was his second labor he had seen (line 1076-1084)... But he was really good and interested in me. Ya, he was talking to me afterwards about my family and just different stuff. Ya, it was good" (B, line 1091-1105).

Carlynn claimed that conversations with health care providers gave her an opportunity "to get used to the environment and staff" (B, line 427) which she did not experience during her first birth:

> I had a nice chat with the nurse, you know and a nice chat with the resident. He did a very thorough history and I educated him on a few things. He was a very friendly person, you know, we chatted in the hall a few times... (B, line 429-433) I did talk to the nurse I had on the earlier shift, um, about what was happening (in the hospital). She was part-time, and we talked about what was happening with her job and the benefits of working part-time and stuff" (B, line 1318-1323).

Lack of Dialogue

Participants in the study shared their experiences in which they were unable to engage in friendly dialogue and establish rapport with their health care providers. Mike and Allison, despite their efforts to establish rapport, perceived their care provider to be "cold"; uninterested in them as human beings, and unable to relate to them on a personal level:

> When we first met her (nurse), I really went out of my way trying to be nice to her. And I was talking to her and asking her general questions, nothing personal, and she just kept on being cold. And I thought, boy, it's almost like a "Nurse Ratchet" [an undesirable nurse in the movie "One Flew Over the Cuckoos Nest"]. (Allison interjects) Ya, ya, and plus we even shared with her some of the people we know who are nurses, all this kind of stuff, and her only comment was "Oh" (Mike & Allison, B, line 973-988)... When you called her in she was very professional, but other than that she didn't go out of her way, you know to come in and check up on you. Basically if you needed something you would call her and she'd come in, but she never came in and spontaneously say, how's it going? or can I get you anything?. She was very professional in terms of this is my job and this is what I'll do, but not any more. She just wasn't interested in our experience and making us feel like we're human. She couldn't relate to us or what we were going through. Ya, her non-verbal expressions, like I said, professional, to the point of being cold (Allison, B, line 677-701).

Listening

Listening refers to the act of recognizing what clients are saying with their words and also expressing through their nonverbal behaviors. Listening involves two distinct actions: first, interpreting the clients' verbal messages; and second, observing and interpreting clients' nonverbal behaviors, such as postures, facial expressions, and movements.

The act of listening to client's nonverbal messages was identified as extremely important by several women in the study, as women commented that they were focusing their efforts inwards to cope with the physical and psychological demands of labor. For example, Lauren noted that she was unable to express her needs during her precipitous labor: "it was happening so fast, and I didn't really have time to think about anything. It was just happening and we were, we were in shock the whole time" (B, line 1020-1024).

Demi, Jenny, and Sandy perceived that their health care providers were "interested" and "aware" of their needs as they appropriately interpreted their behaviors during labor. Demi recalled that she went back to the hospital because she "couldn't take it any more at home" and was "afraid they (nurses) were going to send us home again" (B, line 67-68). However, Demi described: "as soon as they (nurses) had a delivery room open they admitted us right into a room... they basically knew that we needed a room 'cause I pretty much couldn't walk" (B, line 233-234).

Jenny also recalled how her labor was "getting pretty heavy and intense" and was unable to respond to routine admission questions. Her nurses recognized her discomfort and redirected their questions to Jenny's husband:

> Ya, I really didn't have to say anything. Um, to be honest with you, at the time I think my labor was intense and that part of me didn't feel like discussing anything (B, line 514-518). The nurses are asking me questions and of course I couldn't talk to them so (husband) did the talking and they asked him the questions. And the two nurses that were at the station they figured that they probably didn't have time to go through the fetal assessment stuff so they just put us right into the birthing room (Jenny, B, line 124-126).

Sandy and Dale expected "to go to battle" with their health care provider when they decided not to have routine eye drops administered to their newborn son. They perceived that their care provider was listening to their request and were pleasantly surprised by her response: "I said, we really don't want the erythromycin but we do want the Vitamin K. And she (nurse) said, "Okay, I'll just mark down refused on the erythromycin. It's no big deal" (Dale, B, line 759-763).

Not Listening

Listening refers to the act of not responding to what clients are saying with their words or expressing through their nonverbal behaviors. Several participants said that their verbal messages or nonverbal behaviors were not recognized by their health care providers or were not interpreted as valid. Demi and John shared their experience of expressing their wishes to their health care providers:

> I was in a lot of pain. I couldn't even walk... so I asked for an epidural. The first (nurse) in there wasn't really listening. She sort of just wanted me to go in the shower... (John adds) Even when you asked straight out for the epidural they tried to get you to go into the shower still, didn't they? (Demi & John, B, line 99-128).

Lauren noted that she was encouraged by her care providers to push her baby out after her cervix had reached full dilatation, despite her objections that she did not have the urge to push:

> ...I didn't feel like I had the urge to push. And like I was still getting the cramps, but I just didn't feel like I had that intense feeling that I had to push. So, they're all telling me to push and I'm going, but I don't have to push. And they're saying, "push, push, push" (B, line 432-439).

Tracey and Doug commented that their care provider did not believe them when they announced that their baby was about to be born in the shower, when in fact the baby arrived five minutes later:

> I was so excited and thought that this is really happening fast. I ran out to the hallway and told another nurse... that the baby was coming. Then I ran back to the room and Tracey was kneeling on the floor in the shower and screaming that the baby was coming. I mean she was really serious. The nurse came running in and tried to get Tracey to relax... I don't think she believed Tracey, because she said that it was too soon and maybe she should have a shot (of medication) (Doug, B, line 198-208).

Tone of Voice

Three of the participants in the study commented that their care providers spoke to them in "slow" and "calming" voices which they perceived as comforting. Lauren described feeling "really scared" at the onset of labor, and recalled that her physician spoke to her in a "very calming voice" (B, line 559-560). Madeline also remembered the tone of voice and visual imagery used by her midwives during labor:

> You know, she'd talk about "concentrate on your cervix dilating" and just in a real calm voice, you know, sort of talk me through the contraction (B, line 237-243)... the voice, like it was... not so much what they said to me but how they said it. They had this certain calm. You know they were always calm. They were always reassuring. They always gave me confidence in the way they spoke and they were always talking slowly. They all spoke quite slowly and calmly" (B, line 1937-1946).

"Rushing"

Several of the participants in the study commented that their care providers were constantly "rushing" while they provided their care. Madeline described that visits with her physician were "quick, 5 minute visits" , which did not enable her to ask questions, discuss aspects of childbirth, or get to know her care-giver. Tracey commented that her health care providers appeared to be "rushing in and out of her room" while she was laboring; their "brief" presence in and out of her birthing room made her feel like she was "not a priority" and not a "legitimate" patient (B, line 1012). Jenny also noted her experience in the antenatal period:

> I try to pick and choose what I think are important questions and then after I leave I sometimes feel, oh, I didn't ask this and it was important to me, but you know, how you get rushed in and out of there... I've tried to bring things up with him and um, I think patient load is also a big difference. Like I don't feel that when I go there he has the time to talk to me and I feel kind of rushed when we're in there (A, line 210-220).

Addressed Feelings and Concerns

This manner of communication refers to health care providers abilities to recognize and validate their clients' current feelings and their meanings. It was identified by women in the study as an important way of adding a dimension of understanding between childbirth participants. Madeline and Lauren commented on how frightened they were at different times throughout labor and how their care providers were sensitive to their feelings and concerns. At six o'clock in the morning Madeline called her midwife "to tell her how we were doing and that we're having some contractions" (B, line 62-63). Sensing Madeline's anxiety regarding a home birth, Madeline's midwife asked if she wanted her "to come" to their home. Madeline remembered: "And I said, 'yes'. I wanted her to come over because it was starting to get worse and I was nervous" (B, line 68-70).

Similarly, Lauren was anxious while in labor and described how her health care providers addressed her fears:

> I was really scared. Actually, the one nurse, she knew. I'm trying to remember what she said. I can't remember but it was very comforting. Like she knew I was scared 'cause I remember seeing my knees shaking like this 'cause I was so nervous. And, (doctor) was good. He was. He would hold my hand and he'd say, "I know you're scared Lauren and it's going to be okay" (Lauren, B, line 548-556).

Rejecting

Rejecting refers to the refusal to discuss feelings or subjects with participants in the study. Participants identified that this way of communicating made them feel ignored; in that what they considered as important, was treated as insignificant. Rejecting also refers to the exclusion of the participants in conversations between staff members in their presence. Sandy noted that her care provider: "just never would deal with the actual question" (B, line 268-269). Julia and Jenny commented that their health care providers did not directly answer their questions:

> My husband finally asked the nurse how the baby was and she just said they would know more after the ultrasound. She looked very nervous and just kept chattering... The doctor came in and told us that he was going to break the water bag to speed things up. He was nice, but he looked very busy. Um, like when I asked him a few questions, and I don't know what they were, but he just kept writing something on the chart and just ignored me (Julia, B, line 246-251).

> ...like we haven't discussed my needs for the delivery yet and that's making me feel a bit anxious. Whenever I sort of bring it up or ask questions, it's sort of like, next visit, next visit (Jenny, B, line 164-168).

Participants also commented that their health care providers discussed their cases among other staff members in their presence, and did not involve them in the conversation. Kari and Doug recalled that their care providers were "whispering" in and outside of their birthing rooms. Julia commented:

> ...they were talking about doing an ultrasound and getting a specialist to see me. My husband and I were trying to stay calm but we were getting annoyed... Everyone was talking to each other but they didn't say anything to us. I really felt like I was sitting in a corner watching the entire thing (B, line 118-146).

"Asked Preferences"

Several participants in the study identified the importance of being asked their labor and birth wishes or plans, as it conveyed respect within the relationship and their health care provider's desire to understand and facilitate their wishes. For example, Demi and Carlynn were asked if they would consider having a student learner attend their births. Allison and Lauren's care provider's inquired if their spouses wanted to cut the umbilical cords, and Madeline's midwives explored her preferences for labor and birthing positions. Jenny noted that her care providers inquired about her preferences for pain control in labor: "the nurse came in and asked me if I needed any medication or anything, and I just told her that I was fine without it" (B, line 782-783).

Anna described that her health care provider explored her requests upon admission to the institution:

> ...with taking the history and stuff. And at that point she asked if there are certain things you really want or don't want or whatever? Are you planning to have an epidural? Are you planning to take something later on for the pain? Just you know, the IV or whatever. Different things like that. So it seemed like she wanted to know a little bit about what we wanted and didn't want (B, line 1178-1190).

Failure to Ask Client

Several participants in the study commented that they were never asked about their individual preferences or desires for childbirth, and perceived that their care providers were "indifferent" to their needs. Feelings of depersonalization in the hospital setting made several participants reluctant to inform their health care providers of their preferences, for fear of being classified as 'difficult' patients. Julia and Tracey recalled their experiences:

> No one really asked me what we wanted. I guess, it's my fault that I never said, but everything was just so awkward... You know what it's like in hospital, that's the thing. You don't want to be difficult. No one considered what I wanted. I felt angry and like a freak. I felt like all these people kept coming into the room to see the freak (Julia, B, line 244-268).

> It was like everything I wanted, she (nurse) did exactly the opposite, like it didn't matter to her. And it was frustrating 'cause we showed her the birth plan when we came in. She looked at it, sarcastic-like, and I don't think she even read it... but I wanted to try to be drug-free, and she kept saying that I need a shot, maybe have a shot now. Like with the monitor. I didn't want to stay in bed forever, you know. But she would put it on and leave us to wait. Finally, we took it off so I could walk around. It was easier when I walked and we saw her in the hall. She was really quiet and didn't look at us. We didn't know if she would ever come back and then if she thought we were trouble (Tracey, B, line 177-202).

Assumed Knowledge

Three of the women in the study commented that due to their previous birth experiences, their health care providers assumed that they possessed proficient knowledge of labor, birth, and newborn care. These participants felt like they were "abandoned" by their care providers and were reluctant to ask for assistance. Carlynn and Jenny noted their experiences of feeling" awkward" and "incompetent" when uncertain of how to perform care of their newborns:

> ...I think they made assumptions I knew what I was doing, like, 'cause they basically let me on my own and no one told me about how to care for the cord or anything like that. And you know I remember thinking, do I know what I'm doing? When I got home I was just thinking, Is there something I should have found out that I didn't know? (Carlynn, B, line 1395-1406).

> I thought, I'm not so sure of what to do with all of this and so I fumbled for a little while and finally asked the nurse. She sort of giggled at me and she goes, "I thought this was your third baby". I said that it is, but I've got two boys, you know, and I know what to do with them (Jenny, B, line 1296-1302).

"Told To"

Several participants in the study described how they were "told to" perform specific tasks and actions without being offered additional information or explanations. Such commands were perceived to block communication and offered participants no choice or control, other than to do as they were told. Julia described:

> ... she (nurse) told me that I was going to have an epidural and I was really scared because I didn't know what was going to happen. I have friends who had the drip and their labors were very hard, and um I felt like everything had gone wrong. I was not very enthusiastic about having an epidural, but she kept telling me that I needed one. I didn't have one with any of my other children, you know, and the big needle really scared me (B, line 194-2-202).

Kari recalled her experience of being "talked at" in labor:

> All the time it was just, do what I say. You know, now you are going to lay on your left side, now you are going to lay on your right side, now you are going to do this, now you are going to do that. They didn't talk to me, they talked at me (B, line 455-459).

Demi stated that she was not offered a choice during labor and immediately following the birth of her daughter, and she was commanded to complete specific actions. When Demi's contractions were becoming frequent and intense , she requested an epidural and was "told" three times, "to go into the shower"; she concluded that "they didn't want to go get the anesthesiologist and do that for me" (B, line 106-107). Immediately following her birth, Demi was "told" to breast feed, although it was not something that she wanted to do at the time, and said:

> That's what they just told me to do. I didn't think it was a big deal and I don't know why she couldn't have waited for 2 hours or so. She (nurse) yanked on it and I ended up with a big scab on my breast. (B, line 243-246).

Madeline described an antenatal experience with her physician:

> Sometimes I get lectured, like he gave me a lecture on my age and told me that I should quit work sooner and this kind of thing. It's more that he was looking for something wrong with me all the time and told me to do things I really wasn't comfortable with (A, line 239-242).

Uncertainty Versus Control

Throughout the interviews, participants expressed their concerns associated with labor and birth, which emerged from their attempts to regulate the balance between uncertainty and control. The effects of uncertainty were perceived to be realistic and unfavorable components of childbearing, originating from the unpredictability of the birth process, previous birth experiences, and the hospital environment. Control was recognized as a concept which was desirable during childbirth, and was commonly acknowledged as a way of participating in decision making. Carlynn provided a strong example in the data of gaining control through making choices, and having a say in decision making :

> I think control is the state and decision making is one of the tools that you have to achieve control. Decision making is definitely one of them, saying I choose this over that. Or I request this... Another thing is being able to voice what you don't like or what you want to change. So there are various tools and then there are internal ways of gaining control so that you can make all the decisions you want. But you have to have the sense of control, that I am in control here. So I think there are tools you do outwardly and also the internal preparation and stuff. A mutual state (Carlynn, A, line 568-589).

Participants also reported anxieties about losing control over their bodies in an unexpected birthing event, and the fear of losing control of their identities in the hospital environment.

Unexpected Events and Loss of Control

Several participants expressed their fears regarding the unpredictable nature of childbirth and losing control over their bodies. Lauren compared the uncertainties of life to the uncertainties prevalent in birthing, and said: "there's a risk associated with everything you do" (A line 431-432). Kari and Allison commented:

> ...nobody wants to have interventions like episiotomy, induced birth, or cesarean section, but I have to bear in mind that some people do have this experience. They do get induced and they do have cesarean and it could happen to me (Kari, A, line 256-260).

> I really feel like you want to keep an open mind and a positive attitude, but at the same time you want to be realistic. Anything could happen, you know... I wanted, obviously, the baby to be not in distress or anything like that or have my blood pressure go up and, I mean, all those things are things that I don't have control over, you know (B, line 1380-1395).

Anna noted that despite making healthy choices during her pregnancy, there was a possibility that "something may happen" in labor and she would not have a vaginal birth:

> I have always made a decision when I am pregnant, to live very healthy. We don't smoke and we eat whole grain foods and live a very healthy lifestyle. So during pregnancy I am very conscientious about, you know, I have to have a splitting headache before I take one Tylenol or something. I take prenatal vitamins and have made the decision to do everything to be as healthy as possible and give the baby the best chance as possible... I try and give the baby as good as chance as possible before the baby's born... (A, line 772-795). I realize it's very unpredictable what happens in labor. You know, you can sort of think in your mind that everything will be smooth and everything will be fine. But I also realize that during labor, something may happen that makes thing different. It would be really great if everything went smoothly but we realize that there are no absolute guarantees for a vaginal birth (A, line 277-292).

Carlynn expressed concerns about the uncertain size of her baby and her ability to birth:

> The biggest anxiety I have is that the baby will be big. And partly it comes from people looking at me and going, "you have another month to go?" I can feel just how big the baby is, like he's big and strong. But then again, that's nothing I have control over. And I like having large babies because I think that if they have a little fat on them they are contented to start, you know, they are strong and they can sleep. And so, I would rather have a good, healthy big baby, but I am concerned that if it's too big it will be a really hard labor. Or the baby will get stuck or something like that. That's the concern I have (A, line 626-638).

Loss of Identity in the Hospital Environment

Participants in the study described their concerns related to the uncertainty of the hospital environment and losing control of their identities. Some participants commented that they were anxious regarding recent "cut-backs" in the health care system and subsequent "changes" which included; "reduced time in hospital", "staffing shortages", lack of support if the nurses were "busy", and getting fragmented care from an array of unfamiliar health care providers. Jenny, Carlynn, and Anna illustrate their anxieties originating from the uncertainties of the hospital environment:

> I'm scared of the big hospital and the policies... I think that's my biggest hesitation was that they're going to have their little rules that you are going to have to stick to and, you know, sometimes it just goes by what the nurses also feel... I realize that the health care system has also changed. It's like you're in there for a day and you're out and a part of me is afraid that I'll be a number instead of a person. Because I think that they tend to forget how much emotions are here. I realize it's a much bigger environment and much busier and you don't expect to be pampered. But by the same means, I think everybody still has to be treated as an individual when you're in there... They don't have to be sour about it, you know, and become this sort of processing line and just pumping everyone through. Still remember that there are people involved (Jenny, A, line 1384-1423).

> And I guess I'm a little anxious too because of the changes in the health care system from two and a half years ago to now. When I first had (first child) they were just beginning to talk about cut-backs and reduced time in the hospital and stuff. And now a lot of these things have been implemented... and I am anxious because I think that morale and the shortage of staff makes a big difference on how much people (staff) can give (Carlynn, A, line 527-535).

> And with all the cut-backs that are happening here, I thought it would be good to have someone that we know is going to be there, instead of understaffed and lot's of people in. It might be hard to get that one-on-one sort of nursing that we had with our first 2 (children) (Anna, A, line 217-222).

Dale and Sandy stated that they were concerned about whether or not their health care providers would respect their personal plans of birth:

> ...we had several thing that we were worried about. For instance, whether Sandy was going to get an IV the minute she walked into the hospital. Uh, we were worried that if that happened there might be drugs administered that we didn't know about. We both felt that if it was at all possible to get through the delivery without analgesics or anesthesia, we really wanted to. So far as we could possibly get away without them. (Sandy interjects) Ya, unless otherwise indicated (Dale and Sandy, A, line 640-650).

Similarly, Madeline feared having to change her birth plans if she had to have a hospital birth:

> ...the fear I had of going to the hospital was that I would lose control over what happens. That somebody else, because you're in a different environment. You're not in your own home, you're a patient... you lose some of that control and that was the thing with going there that worried me... if I have to go to the hospital then we might have to change our plans, so I may not necessarily get what I want if we end up going (to hospital) (A, line 1160-1176).

Previous Birth Experiences

Participant's previous positive or negative birth experiences were identified as a significant influence in how women anticipated their subsequent labors and births, and their ability to maintain control over health care providers in the clinical setting. Positive experiences were described as: "strong" relationships with health care providers, small community-like environments where everyone in attendance was a known "friend", and spontaneous, quick labors and births. Similar experiences were actively pursued by participants in subsequent births.

In comparison, previous experiences which were perceived as negative included: induction of labor, extensive episiotomies, being "tied down" to fetal monitoring equipment, and other "unnecessary" interventions. Participants expected their impending births to be similar, despite the fact that they expressed their concerns to their health care providers and sought alternative options in an attempt to attain control.

Outcomes

Outcomes refer to the perceived results of decision making and communication interactions between participants and their health care providers during childbirth. It is important to view this theme, not as a single phenomenon, but in the context of the whole birth process, and dependent on the perceived expectations of the participants, birth plans, patterns of effective and ineffective communication, and the effects of control and uncertainty. Descriptions of this theme were classified into two major categories, which included; passive and collaborative decision making behaviors, and perceptions of the birthing experience.

Passive and Collaborative Decision Making Behaviors

Five behaviors were identified as part of passive and collaborative decision making and reflected the participants involvement in decision making during childbirth. These behaviors were self-confidence, confronts issues and concerns, expresses thoughts and feelings, considers self to have health care rights, and makes own choices. These behaviors varied among participants in the study and appeared to exist along a continuum; passive decision making behaviors were recognized to be situated at one end of the continuum and collaborative decision making behaviors at the opposite end.

Passive behaviors consisted of being less involved and less responsible in making decisions related to care. In contrast, collaborative behaviors referred to active involvement, in collaboration with health care providers, in both decision making and taking responsibility during childbirth. The following behaviors are presented in Table 4-4.

Possesses Self-Confidence

Ten of the twelve participants in the study expressed self-confidence and perceived that they had the abilities to birth and attain their childbirth goals. These women described feeling "confident" about providing input in making decisions, as compared to two participants, who stated that they "hoped" to participate in decision making. To illustrate this dichotomy, exemplars from the data include comments from participants who had opposing levels of

Table 4-4

PARTICIPANT DECISION MAKING BEHAVIORS

Participant #

Behaviors	1	2	3	4	5	6	7	8	9	10	11	12
Possesses Self-Confidence	+	+	+	+	-	+	-	+	+	+	+	+
Confronts Issues and concerns	+ -	+	+	+	-	+ -	-	+ -	+	+	+ -	+ -
Expresses Thoughts and Feelings	+ -	+ -	+	+	-	-	+ -	-	+	+ -	+ -	+ -
Considers Self to have Health Care Rights	+ -	+	+	+	+ -	+	+ -	+ -	+	+	+	+ -
Makes Own Choices	+ -	+ -	+	+	-	-	-	-	+	+	+ -	+ -

+ exhibits **consistent collaborative** decision making behaviors

- exhibits **passive** decision making behaviors self-confidence. Jenny said that she 'believed in herself':

> You hate to be really finicky or fussy you know, because I realize that they (health care providers) have a job to do, sort of thing. But by the same means, I'm a person that likes to be in control of the situation and I feel like it's my body... Ya, and I think in my guts tell me that I'll have a vaginal delivery and so I've kind of been following that instinct... I'm feeling confident that things are going to go well, the way that I want them to go. I am just going to stay positive and not even think about if things aren't right (A, line 53-82).

In contrast, Lauren was not feeling confident about her ability to tolerate the pain of childbirth, which she believed would impair her ability to participate in making decisions. Reflections of Lauren's self-confidence were filled with "hopes" and "wishful thinking":

> So, I'm hoping I'll be able to um, deal with it all, really better than I am expecting I will. And that, you know, that I'll be able to communicate in a reasonable way, that kind of thing. Ya, I'd like to do that too but I'm not quite sure. Maybe it's just wishful thinking, that I'll be able to. I hope that I'm not in too much of a state. I don't tolerate pain very well (A, line 627-635).

Confronts Issues and Concerns

Confronting issues and concerns, which included an array of various matters, referred to the identification of actual or potential dilemmas and to the seeking of appropriate resolutions. Information-seeking behaviors were recognized as the participant's primary means to both identify and resolve their issues and concerns. Of the twelve participants in the study; five women consistently challenged their issues and concerns, five women 'did not feel comfortable' confronting their concerns some of the time, and two participants were never able to face their childbirth concerns. Sandy and Dale offered a powerful example of how they sought resolution to one of their birthing dilemmas, which was choosing an appropriate primary health care provider who was willing to work cooperatively with them during their birth:

> ...we searched long and hard for an obstetrician and actually visited several. While we were making a choice, many things went into that. We had a lot of concerns about what actually was going to happen in childbirth and how much was going to be taken away from us. In other words, to the extent our wishes were going to be respected. And we didn't want to, all those wishes, would not be compatible with our obstetrician's. In other words, we didn't want to be at odds with an obstetrician (Dale, A, line 177-195).

Participants stated that they sought to resolve their birthing concerns by requesting information from a variety of sources, which decreased their feelings of vulnerability with a new or subsequent birthing experience. Many of the participants probed and questioned their health care providers regarding issues or procedures they did not fully understand. Information which was received by the participants during the childbearing cycle secured their feelings of 'control'. For example, Allison commented:

> ...we would talk with (nurse) and ask her different questions when we didn't understand. You know, we'd basically say, "Is this what's going on? Is this what's happening?...You know, more for validation and information, which comforted us and helped us feel like we were in control of what's happening" (B, line 1316-1326).

Mackenzie recalled how she solicited information regarding newborn care to resolve her concern in the postnatal period: "I was frantic... So I phoned the hot-line to find out for sure. You know, logic told me that it wasn't, but I just wanted to run it by someone and find out so I could relax" (B, line 1022-1025).

In comparison, several of the participants stated that they did not confront their issues or seek resolution to concerns associated with their births. Regardless of the fact that they described feeling "worried" about particular aspects during labor and birth, they did not say or do anything to alleviate their anxieties. For example, Carlynn did not resolve her concerns that she and her husband were feeling "unprepared" for their impending birth, as "child care is just one more hassle" and her "husband's schedule is very busy" (A, line 158-159). Jenny recalled that she did not explore the implications of a possible cesarean section: "I haven't really, you know, found out a whole lot of what's involved. It's sort of like, that's almost a fear for me and so I'm just trying to avoid it..." (A, line 1578-1583). Lauren was concerned as to whether or not her physician performed "routine" episiotomies, but stated that she may "ask him about it later" and "didn't think he did"(A, line 902-1013).

Expresses Thoughts and Feelings

This theme refers to the sharing of thoughts and feelings, either prior to or during childbirth; information which usually involved matters pertaining to the participant's birth plans. While three of the women or their labor support persons consistently communicated their thoughts and feelings in verbal, non-verbal, or in written form, six participants did so only part of the time, and two women did not make their thoughts and feelings known at all. Anna is a participant who consistently communicated her plans to create a "meaningful, family birth experience", and commented that she sought written permission from the unit coordinator at the birthing institution to allow her two school-aged sons, midwife, and family friend to attend her birth. Anna noted that this behavior helped to achieve "control" of her birth wishes:

> I think by making the decision to write the letter (outlining plans of birth) to the unit coordinator, we have taken a lot of control. And with expressing to (physician) our requests it makes me feel like we do have more control... So your decisions give you a lot of control over the situation. And then you need to make a decision and say, well this factor has come in and has caused us to change our plans, but you have a say in the decision (A, line 808-817).

Demi, Mackenzie, and Sandy and Dale described their verbal efforts to make their birth wishes known to their health care providers. Demi, who planned to make decisions "as she went along", stated that she had to be assertive in expressing her needs of refusing to take a shower, demanding an epidural, and telling medical students to stop their frequent vaginal examinations. Other participants commented:

> ...so it was discussed right in the early stages 'cause I said, "if everything goes well I want to leave. I'll only take a room if I have complications or something's wrong with the baby and we can decide then" (Mackenzie, B, line 1509-1515).

> And so making our wishes known to the nurse was the only mechanism we had... we just said, "this is how we feel. This is what we want. This is what we don't want"... We told them that we didn't want the baby bathed and we received some criticism from the hospital for that. But, they did agree not to bath the baby (Dale, B, line 937-1090).

Madeline commented that the continuity of care she received from her midwives provided the opportunity to discuss her thoughts and feelings about a home birth at every antenatal visit:

> Well, I think because we knew them (midwives) beforehand and we talked about what we wanted, that they knew... we knew them all well, because we'd been there for prenatal visits and we did prenatal classes with them and they knew what we wanted. And because they weren't sort of like, they're not someone you just met in the hospital and they don't know you and you have to explain everything. Because they knew us it was more like people that you know really well. They know what you want, what you're feeling and you don't have to constantly explain everything to a lot of different people (B, line 1513-1531).

Several of the participants commented that they lacked "confidence" in informing their health care providers of their thoughts and feelings, as in the experiences of Demi and Tracey, who stated they were not keen on having students attend their births. Despite granting permission to allow students to be present, Tracey recalled that she "really didn't want them" in her birthing room: "I don't know why I said 'yes' when I really wanted to say, 'no way!'... I almost felt guilty and thought I had to say okay" (B, line 1545-1566).

Lauren was so nervous during labor that she was unable to inform her health care providers that the nitrous oxide they insisted she use during labor was completely ineffective:

> So they gave me laughing gas actually and I'm sucking it in like crazy trying to get the, you know, trying to get as much as possible... Actually, it didn't have any effect on me 'cause I could still feel everything. I had it once before when I went to the dentist and it didn't work then either. I was just so nervous and I didn't like to tell them that it wasn't working (B, line 710-730).

Likewise, Allison and Mike were not confident in expressing their true sentiments, that they were not satisfied with their primary health care provider in the hospital setting:

> We thought that she just didn't' have the personality, you know. Not very interested or nurturing. (Mike interjects) Ya. She just didn't match us. There was no way that we could have said, "Hey, we are not very satisfied with you. You're just not happy being with us, you know. Your personality is not matching what we want or what we need. Can we have another choice?" You know, it wasn't like we could have said that so we never even approached it but we really thought it (Mike & Allison, B, line 994-1020).

Considers Self to Have Health Care Rights

Seven of the twelve participants in the study consistently thought and behaved in ways that corresponded with their personal opinions and beliefs . These participants claimed responsibility and ownership of their birth experiences, which referred to asserting their rights to seek appropriate health care providers and working towards achieving their childbirth goals. Women were determined to find a "fit" between their own birthing philosophies and the philosophies of their primary health care providers, which they perceived would enhance their abilities to achieve their goals. The other five participants did not claim their rights as a consumer, despite comments that they were not pleased with their levels of care.

Sandy and Dale were similar to all of the other participants in that their fundamental childbirth goal was identified as the well-being of their babies. Another objective which was expressed by this couple was to be recognized as 'partners in childbirth', rather than Dale occupying a "peripheral role":

> ...very frequently people would tend to address themselves to me. And they'd turn to me even if Dale asked a question the answer would be directed towards me because, of course, I was pregnant and he was somehow peripheral. (Dale interjects) Well the partnership was important to us for sure. And this was actually a barrier that we did run into several times throughout the pregnancy and delivery. And I suppose we noticed it because we tended to dig our heels in about it. We wanted to go throughout everything together. We went to every single doctor's appointment together and we wanted to be together for all the tests and things... So the security was there for us you know, as tax payers, paying our premiums for Alberta Health Care, we felt we had a certain privilege to that (Dale, B, line 877-914)..

Madeline stated that she sought to achieve her goal of client-centered care with a midwife, which meant venturing outside the realm of the current health care delivery system:

> They (physicians) only want to find something wrong with you and if something's not wrong with you then they let you go. There's no asking or answering questions about you. There's no sort of promoting health and they aren't helping to prevent disease or to help you stay healthy. And so, that kind of really bad experience with my obstetrician and I also basically found out that there's no way the midwife could deliver in the hospital and I should leave work early and do all these things. Rather than the obstetrician giving me options he was telling me what to do, which I don't like. Whereas the midwife has never told me what to do. She never once made it known whether she prefers us to have a home birth or hospital birth. It's always been whatever we want. She basically gives us options and lets us decide. So after that experience we just thought if we have the baby in hospital I couldn't bear to think that after we do all the work he just comes rushing in and takes control of it. That just really bothered me. To me it should be what we want and how we want it (A, line 244-264).

Mackenzie was determined to find a physician who would allow her to leave the hospital immediately following the birth of her fourth child:

> But it wasn't so easy in the beginning... I had interviews with 23 doctors to find somebody that, even though it's all in place now, I still had trouble finding a doctor that was supportive of it. Right? There are problems with the legalities, but there are people willing to help you have the experience that you want, but you have to keep on going and searching... (B, line 1960-1972).

In contrast, Jenny was "uncomfortable" with her physician during her pregnancy because she perceived they were unable to "build" a relationship. Jenny struggled with the notion of searching for another female primary care provider:

> I wanted a female doctor because I thought it would be easier to talk with one, you know a female doctor... So whenever it seems like something new comes up I have to go see a different doctor and I've seen three different doctors throughout the pregnancy which has been difficult in building a relationship. I just feel like I can't ask her the things that I normally would like to... in hindsight I think I would switch doctors. It just seems like, you know, as you get further along into your pregnancy, I kept thinking things will get better. Things will get better. Now it's like, maybe it's too late to be changing doctors and uh, I think in hindsight I would have followed by intuition a little bit more closely and just switched. 'Cause I wasn't comfortable right from the start so I should have switched I guess (A, line 99-235).

Carlynn, and Lauren were unable to articulate their childbirth goals and subsequently had difficulty expressing their needs to their health care providers. For example, Lauren stated that she wasn't "too certain" what she wanted for her birth, and trusted that her care providers would do what was "best" for her (A, line 522-534). Carlynn, who did not have any childbirth expectations and described vague goals, commented that she did not inform her physician of her goals and objectives, as she was reluctant to abuse the health care system:

> Ya, and I was going to talk to him (physician) about that (not wanting an episiotomy), but I haven't yet... And so, I'm usually cautious about wasting health care visits and health care resources, and so I'm afraid to spend a lot of time talking and being a bother, and insist on being seen when perhaps I don't really need to be seen" (B, line 1210-1216).

As well, several of the participants stated that they felt 'powerless' among health care providers and were not able to achieve their needs. For example, Tracey stated that she wanted to spend time bonding with her baby immediately following the birth. Although her care providers were aware of this desire, the baby was promptly taken away to the nursery:

> I really wanted to hold my baby and I told them that. I could see her and Doug over at the crib-thing, but they said that I had to wait until he was finished stitching and that. It seemed to take forever... So then they wanted to take the baby to the nursery for some check-ups and things. I asked if she could stay for a while, but they said that was not possible and I don't know why because she was absolutely fine... And I felt like I couldn't say anything because they are in charge (Tracey, B, line 255-267).

Makes Own Choices

Four of the participants in the study commented that they encountered situations where they were given opportunities for, or were engaged in making choices about their health care. The ability to make their own choices was identified as enhancing their feelings of 'control' during childbirth. The other eight participants commented that they were inconsistent or passive; unable to make their own choices due to a variety of factors, including: lack of opportunity, lack of confidence in making choices, and communication barriers.

Jenny, Madeline, Anna, Sandy, and Mackenzie commented that seeking and receiving alternatives from their care providers, and participating in choices assisted them to feel more 'in control' during their labors and births. Jenny noted: "I wanted to know, and for them (care providers) to give me choices.

There's certain things that I wanted to have definite control of, that I wanted a choice of" (B, line 1245-1249). Madeline commented:

> I like to know exactly where I stand in the process... It was always up to me if I wanted to do that or not. Which I think was a big factor. Because I think, when you feel like you're losing control, feeling like you just can't handle it anymore, the worst thing is for someone to take more control away from you and say, "Well, do this and do that". They (midwives) never took that away from me. It was always me. Even though I felt like I might have been losing control of things because the pain was so bad, they would always give it back to me. You know I always felt like I had control over everything. They always left it up to me. You need to have some safety and comfort and to give you the confidence to work things through and not have someone taking over (B, line 1083-1130).

Madeline also stated that her choice of a home birth environment was instrumental in achieving feelings of control over her childbirth:

> Also, I didn't want a controlling environment. I want to be in a comfortable environment where if I want to get into the bath or shower or I can do anything I want. It's more conducive to whatever I want. I will listen to suggestion that (midwife) says... but then it's up to you if you want to try them. You can just take your time. That's also what I mean by having control (A, line 565-571).

In comparison, Carlynn and Lauren stated that they were 'obedient' personalities, and were more comfortable having health care providers choose their activities for them during labor and birth:

> They (care providers) decided about a quarter to two, this is at night, that they would run a drip and get things going 'cause (physician) was delivering a couple of other babies and he figured he might as well get me going... And I appreciate that, like when you're at the point when you can't make decision for yourself that people are going to step in and tell you what you need to do. Like I said before, there wasn't anything that I really had to disagree on, so it was more agreeing with what they were doing. So I see that as being quite passive (Carlynn, B, line 1642-1692).

Kari, Demi, Julia, and Tracey noted that their health care providers influenced their opportunities to make choices by offering consequences rather than alternatives. Statements to the participants, such as: "I will..."; "you will..."; and "if you don't... , then..." were perceived as strategies used to gain participant compliance. Kari perceived that she "had no choice" and was not given any information from her care givers, other than statements regarding the potential consequences to her baby:

> ...'cause like in my case I had no choice. They kept saying, "Do this and do that or else something tragic will happen to your baby". You know there's no choice and there can only be one possible decision to make. But knowing full well there's no decision to make, you have to go this route... (B, line 731-756).

Perceptions of the Birthing Experience

The second category in the data reflects the participant's perceptions of their birthing experiences, which varied among women in the study between achieving their childbirth goals and not achieving their childbirth goals. This data was provided in response to the interviewers final question of, "How would you describe your childbirth experience?" Several of the participants provided rich descriptions of their desired and actual involvement in the childbearing process, and also shared their perceptions of communication barriers which prevented them from achieving their childbirth goals.

Positive Birth Experiences

Anna, Carlynn, Lauren, Madeline, Mackenzie, and Jenny commented that their birth experiences were positive; they were content with their roles in decision making and communication with their health care providers, and were successful in achieving their goals. Anna achieved all of her birthing goals which she had diligently planned and described her birth experience as "pleasant":

> It was very, very special. Um, you know, like when I remember the atmosphere and even walking down the hall and stuff, (midwife) would

> be there, and you know (husband) would walk along sometimes and the kids would come out of the playroom and walk through the halls with me, so it was really, really nice. And yet, you know, it's like people would describe a home birth or something, of having the people you want here and all that kind of stuff, and yet, knowing that they were monitoring me and the baby. And I knew she was doing okay with the contractions... And so, I wouldn't change a thing. There wouldn't be a single person that I'd say, you know, I wish that person wouldn't have been there or had a better attitude or I wish that wouldn't have upset the kids. You know, it was really great and I think that all the preparation went a long way and having the confidence that this is exactly what I wanted (B, line 1750-1797).

Carlynn and Lauren also stated that their birth experiences were positive as they completely relied on their health care providers and the technology to guide them through childbirth. As these two participants did not have any predetermined birthing goals, they did not seek to actively participate in making decisions. Both women noted that they felt a part of the birthing "team" because they were continuously informed of their progress and the choices that their health care providers made for them. Lauren expressed great delight in the fact that her birth was quick and that she survived the "ordeal" (B, line 1772). Carlynn said:

> I just think it was a very positive experience. The support from the health care professionals was what I needed. You know, they were very giving and that was very helpful. And they were very respectful and just the warmth of the relationships... And you saw yourself being, you know, more of a get it together, as opposed to their doing this to you. You're more of a team because of that I think. I appreciated that (Carlynn, B, line 1737-1763).

Mackenzie reported that she "would change nothing" when reflecting on her personal birth experience, however she commented on difficulties associated with the lack of continuity of care in the hospital setting. Having had "three or four" different health care providers in the hospital setting, she was constantly "educating them" about her plans and wishes. Mackenzie did not view this as problematic for her own self, but wished she could "change the system" for new mothers who were not very assertive in achieving their goals:

> You know, so many of the new mothers I know don't get choices. Just having choices and not looking at one person's experience and just cattling everybody off. That really bothers me. Because my whole problem when I started laboring is that they were cattling me off with everybody, you know and saying, "No, you got to stay in overnight and you got to stay for a couple of days and you got to do it this way and we're going to give your baby sugar water. But see, I've always spoken up for myself. It's was easy for me. Just going to the hospital and just having the baby and leaving, right? I now have done that with all four children (B, line 1934-1956).

Madeline and Jenny's perceptions of their birth experiences were positive, and they credited their health care providers for their successes in fulfilling their childbirth goals. Madeline, who had a home birth, commented on the relationship she had with her midwife:

> But, like to me, everyone who has a baby should have a midwife, whether you have it at home, 'cause it's not for everyone to have a home birth. I know that. Not everybody's comfortable with it. But even in hospital. To me you should always have a midwife, because you need that, like even if you have your husband there. For the two of you, you need a midwife, 'cause I think that she gives you both confidence. 'Cause how do you know what's going to happen? And when she's there, she can give you ideas on what to do. She gives you confidence... So even if you're at the hospital. I mean, to me you should always have a midwife. Just to get that support from somebody that you trust, not just from somebody you met coming in the door, but somebody that you know and have a relationship with and you trust them. Everybody should have that. Like to me that the way to have a baby. It's a positive experience. It's sort of like having another friend with you. It's not like, you know having someone you don't know. It's like having three friends there with you (B, line 2009-2046).

Jenny inadvertently had her "preferred" on-call physician attend her birth as her primary physician, whom she believed she "did not have a relationship with", was away on vacation. Jenny said:

> He was the one on call so it worked out really well. And he was really,

> really good. I was comfortable with him anyway you know... And I think, like I always said, once you're in labor, you don't really care who's there at the other end or not. But he was really good. He spent a lot of time with us and he told us all about her and went through everything to make sure she was healthy and making sure everything was fine (B, line 382-407).

Jenny also praised the insight of her health care provider for allowing Jenny and her husband to "have our space" during labor and birth:

> ...I really have to give credit to the nurse that was on duty because she just, I think that her personality sort of read into us as well. That, you know, we just wanted to basically be left alone. We were working together really well and she let us do our own thing... I just needed to be going on my own and she was wonderful with that. It went really well and we are really pleased (B, line 553 -575).

Negative Birth Experiences

Demi, Kari, Julia, Sandy, Allison, and Tracey described their birth experiences as negative, for reasons which included: ineffective communication patterns, and lack of continuity of care. Despite their negative perceptions, some participants were hesitant to criticize their health care providers and frequently excused their actions and behaviors. Demi commented that a lack of information and explanations, and constantly "waiting' for information from 'legitimate' health care providers caused a great deal of stress during her childbirth. However disappointed Demi was in the care that she received in hospital, she excused her health care provider's behaviors:

> But, looking at it from their point of view, I think they had six emergency c-sections or so that night. People sitting in the observation room are top priority. They need their staff. But nobody told us that. If they would have told us that at the time it would have been better and we would have understood, but nobody told us. They told us all this the next day (B, line 612-633).

Tracey commented that her birth experience "could have been better" and believed that her preferences and choices were not respected by her numerous care providers:

> You know, I am happy that the baby is fine and the labor went all right, not too hard, but it was not really what we had wanted or expected. We tried to keep positive and in tune with the way we wanted our birth to happen. It seemed like when we got into hospital we had so many obstacles and had to fight and argue for what we wanted. No one seemed to listen even thought we had plan, you know?... it's amazing why everything had to be their way and not ours. We had everything planned the way we wanted and it wasn't like something was wrong with the baby or anything like that. It shouldn't have made such a big difference to them, but it obviously was. Like we had a birth plan and they didn't seem to care. It was like they thought they knew better and I resented that... Next time, we'll be more prepared. We'll do it different (B, line 287-307).

Sandy and Allison noted that they were frustrated and discouraged during childbirth, due to the lack of information, explanations, reassurance, and assistance they received from their health care provider:

> I would have liked the nurse to sort of give us a running dialogue. There was no dialogue at all. No telling us where we're at or what we should expect next. She was just quiet. And maybe that was just her. She seemed like a very self-assured person... if we had a single criticism, with a single strongest criticism it would have been that there wasn't any reassurance... feed-back and information. (Dale interjects) But there wasn't a word of it. And we're sort of floundering in the dark and getting more and more depressed. And I was trying to keep Sandy's spirits up and pretend that I wasn't' depressed (Sandy & Dale, B, line 1633-1672).

Sandy also excused her health care providers behavior when she noted:

> ...she may have felt, I mean with Dale there and your mom, they were giving me so much encouragement and reassurance, and Dale's mom had a cold cloth that she'd wipe me with after each contraction and Dale was helping me with everything. So it may have been that she didn't see a niche for herself just because I had so much support (Sandy, B, line 1514-1524).

Allison stated that if she could change anything about her birth experience, she would have preferred a "more informative" care provider:

> I'd rather have someone who gave us more information about what was happening and stuff like that. I think that would have made a difference in the amount of confidence that I had, you know with the labor part. It just, you know, the attitude and the atmosphere. I guess I think I would have been a little calmer and probably wouldn't have had the epidural is she told me that I was doing well and was almost ready to have the baby. That is the part that upsets me. In retrospect, I didn't really need the epidural because I was almost ready to deliver him. But I didn't know that at the time (B, line 1415-1457).

Kari and Julia commented that their birth experiences were both negative and "traumatic". Both of these women described feelings of depersonalization originating from lack of information and attending skills. Kari reported that she felt "deceived", "totally out of control", and "didn't feel like a real person" during her childbirth:

> I guess if they had told me right away I would have felt more a part of what was going on. Instead I just had to react to what was going on. I don't know. I think that my feelings were (pause), they felt somewhat in charge of my feelings. But, you know, I don't know how to explain it. Almost like a slab of meat. You know, we'll poke this in her and we'll do this and we'll do that. I could have been anybody... I would have changed everything. I know that nothing about my baby would have changed, but I would have liked them, the nursing staff, to have told me earlier what was going on and told me in a gentler, kinder way what was going on. Instead of me kind of stumbling upon it. I wish they would have told me as soon as they knew that something wasn't right and I would have known right away. I would feel better about the whole thing instead of having these terrible thoughts about everything (B, line 1745-1798).

Julia reported that she "felt like a freak" during childbirth as several strangers constantly entered her birthing room, yet gave her limited information about the status of her baby. She offered the following comments to prevent another woman from going through the same experience:

> The (health care providers) need to ask you more and tell you what's

> going on. No one really asked me what we wanted. I guess, it's my fault that I never said, but everything was just so awkward... You know they need to ask you what you want and maybe suggest things like a priest when your baby dies. We were so shocked and never thought about anything like that. And once (priest) came he really supported us and made us feel like human beings... I still feel really sad, but I guess I always will (B, line 319-336).

Summary

The women in this study identified expectations of decision making for themselves and their health care professionals, and also stated various preferences for their births. Each participant wanted to be informed of their status throughout the childbearing cycle and were willing to modify characteristics of their births plans if necessary. Patterns of communication were recognized and perceived to be either effective or ineffective. Effective communication facilitated and encouraged sharing throughout the relationship and included; information giving, explanation, reassurance, and attending. Ineffective communication hindered the formation of a relationship and led to the participants becoming passive recipients of care. All of the women wished to participate in decisions related to their care. Not all of them achieved this. When expectations of participation were not met, the participants were inclined to feel disappointed with their birth experience. The women who were able to communicate their birth plans, and who succeeded in maintaining control over the process, perceived their births as a positive experience.

CHAPTER FIVE

CONCLUSIONS, DISCUSSION, AND IMPLICATIONS

Conclusions

The purpose in this study was to explore and describe the perceptions of women regarding their expectations and experiences of decision making and communication during childbirth. The influencing factors identified by the women and their explanations of the perceived effect of these factors were also considered. The researcher's goal was to expand current knowledge in order for health care professionals to develop an understanding of women's perspectives in these areas and implement appropriate client-centered care.

The first research question asked women about their expectations related to their participation in decision making during childbirth. Women not only identified expectations for themselves, but also anticipated decision making roles for their labor support persons and health care professionals. All of the women in the study expected to be involved to varying degrees in decisions influencing their care. Some participants wanted to adopt passive roles and others wanted to be actively involved, in collaboration with their caregivers in decisions affecting their care. Women's anticipated level of involvement was contingent on their previous birth experiences, knowledge levels, and their personal philosophies of childbirth. Labor partners were likely to participate in supportive and advocacy roles during childbirth. Physicians were expected to make critical medical decisions on behalf of the participants and to facilitate their plans for birth. It was anticipated that midwives would collaborate in decision making and provide continuity of care. Nurses were expected to monitor the participants progress in labor, provide guidance, and offer information.

The second research question explored women's perceptions of their actual participation in decision making during childbirth and findings were related to three content areas; decision making behaviors, perceived uncertainties and control over the birthing experience, and perceptions of the birthing experience. Five behaviors were identified which reflected women's actual involvement in decision making and included self-confidence, confronting issues and concerns, expressing thoughts and feelings, considering self to have health care rights, and making own choices. Behaviors varied among participants and passive behaviors consisted of taking a lesser role of involvement and responsibility and collaborative behaviors referred to active involvement, in collaboration with health care providers in decision making and taking responsibility for their care. Women sought control over the uncertainties of birthing related to possible unexpected events and loss of their identities in the hospital environment. Despite all of the women in the study wanting to participate in self-determined levels of decision making, not all of them achieved this. Perceptions of women's birthing experiences were described in terms of positive and negative outcomes.

The last research question examined women's descriptions of communication in decision making with their health care providers during childbirth. These findings were associated with patterns of effective and ineffective communication, ways in which this communication was achieved, and the development of relationships with their caregivers. Effective communication facilitated and encouraged sharing throughout the relationship. Ineffective communication and barriers to effective communication hindered the formation of a relationship and led to the participants perceiving that they were passive recipients of care.

Discussion

Expectations

Women in the study were not deliberately asked about the expected roles of childbirth participants in decision making and communication, however, anticipated roles were identified for themselves, their labor support people, and health care providers. Expectations of women's roles in the decision making process varied among participants in the study and were contingent on three factors: previous birth experiences, knowledge levels, and personal philosophies of childbirth. Birth partners were expected to participate to varying degrees in supportive and advocacy roles.

Expectations of Self

Previous birth experiences. Women's past experience in decision making during childbirth was a significant factor in their expectations for their impending births. Subsequent birth experiences were expected to be similar to previous experiences and multiparous women in the study wanted to be more involved in decision making in their impending births, as they did "not have a say" in their earlier birth experiences. Other multiparae "hoped" to participate in decision making, although they lacked confidence in their abilities to be assertive in the institutional setting. It was apparent that these women's expectations of participation in decision making were not met in previous births.

This finding is supported in the literature on women's expectations of labor pain and why women choose midwifery care. Beaton and Gupton (1990) found that the multiparous women in their sample expected the degree of childbirth pain in their impending births to be similar to their previous birth experiences. Damsma (1994) reported that the multiparae in her study who received care from both traditional and alternative health professionals during previous birth experiences, expected that they would receive the same kind of care from these caregivers in their ensuing birth experiences. It appears that previous birth experiences in the domains of perceived degree of childbirth pain, kinds of health care providers, and involvement in decision making are important factors which influence women's expectations for their subsequent birth experiences.

Knowledge. Some participants in the study believed that they had adequate knowledge related to birthing, however most women expected that the difference in technical and scientific knowledge levels between themselves and their health care providers would influence their abilities to collaborate in decision making. Although health care professionals were "respected" and "trusted" for the expert knowledge that they possessed, the perceived dichotomy between participants knowledge and professional knowledge made participants feel "vulnerable", "anxious", and lacking "control". All of the women in the study expected to be informed of their status and possible birthing alternatives by their care providers, but were generally concerned that they might not fully comprehend this information because of their inadequate or 'lay' knowledge. Inadequate or unprofessional knowledge levels and the potential for misunderstandings were expected to influence women's abilities to have 'a say' in decisions related to their care and may resign them to be passive recipients of care during childbirth. Hayes-Bautista (1976) reports on the differences between lay and professional knowledge in the American health care system and argues that the differences in the cognition of health-related situations are "problematic" and often lead to health care consumers believing that they are "powerless" (p.83).

All of the participants continuously sought information from formal and informal sources to enhance their knowledge levels. Information-seeking behaviors varied in both the methods of obtaining information and the successes achieved in receiving information. These behaviors ranged from "talks" with friends and family members who were regarded as "knowledgeable" in birthing to engaging health care professionals in discussions related to birthing issues. These findings are consistent with research by Kirkham (1989), who reported on an observational study of 113 women in labor that a dominant theme was the search for information. Similar to the participants in this study, all of the participants in Kirkham's study "wanted to know" information related to their labors and births. Kirkham's findings also substantiate the findings in this study that women varied in the tactics they utilized to obtain childbirth information and varied in the success of their endeavors.

Despite Oakley's (1984) claim that for the last five decades health care professionals have been the primary sources of formal information on childbirth, several women in this study noted that they received limited or no information from their health care providers. They accessed many informal sources which included networks of friends, family, acquaintances, literature, and the media. Several of the participants placed great emphasis on information received from their family members and friends. McCreary-Burke (1994) studied the cultural transmission of women's knowledge regarding childbirth and found that information given to expectant women by their family and friends was often perceived as more legitimate than conflicting information provided by health care professionals.

It is evident that despite perceived levels of knowledge, childbearing women want to be given information from their health care providers in order to fully understand their status and to make informed birth choices. Ralston (1994) established that adequate and appropriate information is essential for women to make informed childbirth choices. In an ethnographic study of labor and delivery nurses, Danzinger (1979) reported that nurses generally assumed that providing more information to laboring women would increase stress levels. It appears that this difference in perception between mothers and nurses could lead to "mismatched caring" (Stainton, 1992).

Personal Philosophies. Participant's who wanted to take active decision making roles attempted to fulfill their personal philosophies of birth as a "natural process" and to gain control over their fears associated with unnecessary medical interventions. The participants who expected to take passive decision making roles reported having less self-confidence, and relied heavily on technology and their health care professional's expertise to make decisions in their best interests. It is known that women's attitudes and beliefs are important influences on their childbirth expectations (Chute, 1985; McClain, 1983; Oakley, 1984; Arms, 1994). Oakley (1994) elaborates on this suggesting that women unify their minds and their bodies in childbirth and opportunities for the blending of body and soul must be available in order for women to fulfill their own individual needs.

Chute (1985) explored women's expectations and experiences in alternative and conventional birth settings and found that women varied in their personal philosophies of birth. She reported that women who adopted 'passive-role' expectations and attitudes towards childbirth might not expect or desire to have any input in decisions affecting their care. In Chute's study women who had physician-attended births did not report any discrepancies between their expected and their actual participatory roles in childbirth, and also identified their infant as the primary focus during labor and birth. In contrast, Chute found that women who maintained 'active-role' expectations and attitudes of childbirth will expect to be involved in making decision related to their care. These women identified themselves as the main focus of attention during childbirth. Chute's findings are consistent to the findings in this study as women often sought to fulfill their personal philosophies of childbirth.

Gregg (1993) argues that some childbearing women lack confidence in their bodies and their abilities to birth, and are socialized to accept the array of obstetrical technologies that are currently available. There is evidence that care providers also trust technology-produced data in place of women's subjective observations about their own bodies. Oakley (1984) states, "it becomes possible to ignore the status of pregnant women as human beings" and when machine-generated data are deemed more reliable than women's self-knowledge, "then the woman does not have to be asked anymore" (p. 151). This philosophy creates the risk of depersonalization and dehumanized care that was evident in a few women's stories.

Expectations of Labor Support People

Women expected their partners to participate in varying degrees of supportive and advocacy roles during childbirth. Supportive roles included coaching, offering encouragement, and providing comfort measures throughout labor and birth. Some women recognized their partner's limitations and stated that they would provide support simply by their presence. These finding are supported by Beaton & Gupton (1990) and Chandler & Field (1997) who identified that labor support people were actively involved in coaching, providing support and encouragement, and as "go-betweens" for the woman and the hospital staff.

The role of advocate between women and their birth attendants during childbirth was identified as important by women in this study. Women realized that they would be "focusing" on their birthing tasks and might be unable to communicate their wishes. Partners were generally aware of birth preferences and were expected to inform care providers of their wishes. It is interesting to note that the need to "fight" or "battle" to have one's preferences respected was a result of several factors, including the medicalized model of birth, perceived vulnerability of women in labor, and the perceived power held by health care professionals. Simkin (1991) argued that women in labor are extremely vulnerable and unable to defend their choices and that labor is often the time when unwanted interventions occur. Some women perceived that their partners would act as their mediator within the institutional system and advocate for them. One participant, who believed she would need to fight for what she wanted in the hospital, avoided this by choosing a midwife-attended home birth.

Expectations of Health Care Professionals

Anticipated decision making roles identified for health care professionals, including physicians, midwives, and nurses, varied among women in the study. It was expected that care providers would make critical medical decisions, collaborate in decision making, facilitate birth plans, and provide support and guidance.

Role of the Physician. Most women in the study perceived that their physicians possessed expert knowledge which would enable them to detect complications during childbirth. Because of this expert knowledge, participants "trusted" their physicians or an alternate, to make "critical medical decisions" in their best interests. These findings are supported by Brien, Haverfield & Shanteau (1983) in which women determined the most important characteristic in selecting a physician as being a "sincere concern for the patient" (p.112). McCreary-Burke (1994) and Breitkreuz (work in progress) established that some childbearing women believed that their physicians would not perform unnecessary medical interventions.

Physicians were generally not expected to provide continuity of care or support during childbirth as the "chance" of on-call and "busy" schedules would most likely prevent them from attending their client's births. A few participants were not concerned with the possibility that an unfamiliar physician would "deliver" their babies, however, for most women the possibility that an unknown physician would attend their births was met with anxiety and general frustration. These findings are congruent with findings from a retrospective British study by Kirke (1980), which examined women's expectations of continuous care from their primary physicians in childbirth. Kirke reported that although most women in his sample did not expect continuity of care from their physicians during labor and birth, they expressed feelings of anxiety and frustration that lack of continuity would potentially occur. Although no expectations for continuous care were shared among most women in the study, it is remarkable to note that women continued to believe that their physicians would facilitate their preferences for labor and birth. It appears that expectant women possess a tremendous amount of "trust" and "faith" in their physicians.

Role of the Midwife. Some of the participants in the study noted that they expected midwives to collaborate in decision making and provide continuity of care throughout the childbearing cycle. These women described childbirth as a normal and natural process, believing in minimal use of technology and interventions during pregnancy and birth. Suspicions of the dichotomy between medical goals and their personal goals were expressed as the rationales for seeking midwifery care. These data are corroborated by Gregg (1993) who reported that technologies usually are utilized as a matter of routine rather than choice.

Two of the women in the study, both health care providers, intentionally sought midwifery care. Anna chose a physician and midwife-attended hospital birth in a birthing room due to the diagnosis of an aged placenta and the possibility that she would not have a vaginal birth. Anna desired a combination of the alternative scope of midwifery practice and the "security" of the hospital environment "just in case" medical intervention was necessary. Madeline decided to have a midwife-attended home birth after feeling disenchanted with the conventional way of birth. Two other participants, who contemplated having a midwife-attended birth early in their pregnancies, decided against midwifery care because of the difficulty of obtaining midwives in the current health care system and the cost involved in such care.

Women in the study sought midwifery care to accommodate their desires for collaborative decision making and continuity of care. Collaborative decision making was defined as a "relationship of sharing" between the woman and her midwife, involving trust, shared responsibility, and shared meaning through mutual understanding. Continuity of care was identified as the other reason for choosing a midwife. It is interesting to note that the word midwife means 'with woman' and denotes the physical and emotional presence demonstrated in midwifery care (Kitzinger, 1984). The benefits of an ongoing relationship with a midwife gave the women the "comforting" assurance of a known care provider at the time of birth. These women also believed that it was important to have a "trusted", "knowledgeable" care provider who was both "familiar" and "available" to provide support throughout their pregnancies, births, and postpartum periods. These findings are consistent with other studies which have explored the choice of an alternative care provider and birth place (Damsma, 1994; McClain, 1981; Schiff & LaFerla, 1985).

Role of the Nurse. Nurses were expected to participate in a variety of supportive roles during childbirth, including providing guidance, offering information, and monitoring the participants progress in labor. Nursing support was commonly identified as a "critical" factor during childbirth as nurses were expected to 'be with' participants during labor and birth; evident when Jenny stated that "nurses make or break" the birthing experience. These findings are similar to those found by Clark-Callister (1993) who identified domains of nursing support in the United States to include "emotional support", "informational support", and "tangible" support, such as physical comfort measures (p. 288). Heaman, Beaton, Gupton & Sloan (1992) and Bramadat (1990) examined the expectations of nursing support in high-risk and low-risk childbearing women. These authors report that "both high-risk and low-risk pregnant women had high expectations regarding support from nursing staff" (Heaman et al, 1992, p. 261). It is interesting that women have identified specific domains of nursing support in childbirth and that these expectations do not vary between high-risk and low-risk populations, even though low-risk women, similar to the women in this current study, are usually not confronted with threatening birthing events.

The amount and quality of support women in this study expected to receive from their nurses during childbirth was dependent on institutional and nurse-related factors such as shift dynamics, the activity level of the units, hospital policies and procedures, and the individual personalities of nurses. Barriers which inhibit nursing support to laboring women and corroborate the findings from this study are evident in the literature. Richards (1982) reports that the institutionalization of childbirth provides an external environment in which nurses must be fundamentally accountable to the organizational hierarchy. The availability of nursing support to laboring women is then confined to the boundaries of hospital policies, protocol, and personnel.

Literature on nurse-related factors, which influences the quality of nursing support provided to childbearing women, was prevalent in the literature. Beaton (1990) examined dimensions of interpersonal roles between nurses and their clients in childbirth. She reports that labor and delivery nurses establish and maintain control over the definition of the childbirth experience and that the perspectives of the women are seldom acknowledged as relevant. Evans and Jeffrey (1995) noted that the individual personalities of labor and delivery nurses determines which approach to client teaching they assume. One approach involves a teaching model in which the "nurse-expert" determines what guidance and information should be provided to laboring women and the second approach involves a learning model in which the nurse assesses individual client's needs and then provides information to suit those needs. These authors concluded that only 27.5% of nurses in their study were "sensitive" to their client's learning needs. It appears that women have important expectations of nursing support during childbirth and that the availability and appropriateness of guidance and information is contingent on institutional factors and nurse-related factors.

Birth Preferences

The women in the study identified that their priority for labor and birth was the well-being of their babies, and that they would put aside their personal preferences and plans, and do whatever was recommended by their carers to protect the integrity of their unborn children. Childbirth plans, of what may or may not be preferable in various circumstances, were attempts to gain control over their birth experience and individual preferences varied among women in the study, including aspects such as: place of birth, family support, labor intervention, birthing intervention, cesarean birth, immediate post-birth, and postpartum care. Not all women were successful in realizing their individual preferences for labor and birth due to the inability to develop a relationship with their health care providers and the lack of continuity of care they experienced.

An element of risk in childbirth was recognized by all women in this study which may have been perceived differently than that of their care providers. Richards (1982) stated that there is concern about safety in the traditional obstetric setting which gives rise to "wide disagreements about how safety is best achieved" (p. 255). Health care providers in this study frequently implied a "doctor knows best" attitude in which they were the only birth participants who had the true interest of both mother and baby at heart, and that mothers may have been selfishly uncaring and not doing what was best for their unborn children. This technocratic perspective maintains that, without medical intervention, the perinatal mortality and morbidity rate would rise dramatically (Oakley & Graham, 1983; Simkin, 1991). This lack of concern was clearly not evident for women in this study as they identified their fundamental birth priority as the well-being of their babies and noted that they would do whatever was recommended by their health care providers to maintain the integrity of their unborn children. Women did not view their preferences for labor and birth as "unsafe" or "radical". It is the opinion of this researcher, based on experience in developing birth plans and examination of the literature on birth plans, that these participant's birth plans were flexible and not potentially harmful to their babies.

Women varied in their ability to convey their birth preferences to care providers. Participants who communicated their plans in written or verbal forms, wished to provide input in decisions involving their care and wanted their preferences to be respected and considered by their health care providers. This input facilitates communication between birth participants and is applauded as the mark of a responsible consumer (Arms, 1994). The successful communication of preferences was contingent on the development of a client-health care provider "relationship". In contrast, participants who were unable to communicate their preferences failed to do so because of difficulties in establishing a client-health care provider relationship, time restraints, and fears of disappointment, which emerged from having unmet birth expectations.

The relationship between women and their care providers was a significant theme which emerged from women's experiences, and appeared to have serious implications on their subsequent interactions and perceptions of their birth outcomes. Women who attempted to communicate their plans of birth to multiple, unknown care providers were met with a degree of defensiveness. The act of sharing birth preferences conveyed a lack of trust in health care providers and subsequently erodes the confidence between mother and birth attendant. Nichols & Humenick (1988) and Richards (1982) support these findings and argue that health care providers sometimes regard birth plans as tools of coercion and evidence of lack of trust. Women in this study may not have been viewed as responsible consumers for sharing their birth preferences, but rather as 'difficult patients'.

Communication

Communication was defined as the means of transferring verbal and nonverbal information between participants, and within the social context of childbirth. Patterns of communication were recognized by women in the study and were perceived to be either effective or ineffective. Effective communication patterns which included information-giving, explanation, reassurance, and attending were perceived to facilitate a mutuality of sharing throughout participant-health care provider relationships. In general, ineffective communication patterns consisted of ways in which care providers failed to communicate with women in the study or communicated in an undesirable manner. These ways of communication include: lack of information, lack of explanation, lack of reassurance, and non-attending.

Information-Giving and Lack of Information

Information-giving referred to the unsolicited conveyance of knowledge, facts, or news from care providers to participants in the study. The different ways in which this pattern of communication was achieved included; introduction of oneself, instruction, suggestion, discussion, and orientation. These methods of communication were perceived to have positive outcomes and included: decreased anxiety; feelings of success and trust in health care providers; increased control, comfort, and knowledge; increased participation in decision making; and, enabled involvement in planning and choosing.

Most importantly, information-giving satisfied women's continuous search for childbirth information. Women, regardless of the degree they wanted to be involved in making decisions regarding their care, wanted to be informed of their progress and status during the childbearing cycle. This finding is consistent with the findings from a British observational study by Kirkham (1989), who reported that women in both consultant and midwife-attended units, without exception, "wanted information with which to orientate themselves" to "time, place, and events" (p.120).

The other theme which emerged from the findings and is significant to decision making, is the concept of choice. Choice is always active and dependent on the definition of the situation and the context of the participants involved in decision making (Kim, 1983). Choice was defined by women in this study as being offered a range of alternatives, adequate information about the alternatives, and the opportunity to participate in making choices from among those alternatives. Women perceived that they had 'a choice' when their health care providers gave them adequate information about potential alternatives, and communicated that these alternatives were safe and would influence their births in a particular manner. Suggestion and discussion surrounding alternatives and choices enhanced women's feelings of control, and facilitated their opportunities to choose and become involved in collaborative decision making during their births.

Lack of information referred to the lack of conveyance of knowledge, facts or news, and included the following; no introduction of caregivers, lack of instruction, opinion-giving, stereotyped responses, and inaccurate information. These ways of communicating were both errors of omission and commission, as evidenced by outcomes which included: increased anxiety, frustration, anger, and concern; decreased control, motivation, and trust in care professionals; and feelings of depersonalization, uncertainty, and fear. Because of the need for additional and accurate information, women described how they suspected worst case scenarios, and had to rely on their senses and environmental clues in order to ascertain information regarding their status and progress during childbirth.

These findings are supported by the findings from Kirkham's (1989) study in which categories of midwife-initiated communication barriers were social class, order of the ward, inexperience, and the inhibiting effect of senior staff. Kirkham reported, through observation, that women of higher social class, as identified on their antenatal records, were given more information than women who were perceived to be of lower social class or "less intelligence" (p. 122). Although this researcher was unable to observe the interactions between most birth participants, it is important to note that of the women who identified on the biographical data sheet that they had completed post-graduate education, three women stated that they had received adequate information from their health care providers. Information pertaining to occupation and education were available to health care providers in this hospital setting.

Women in the study described having various degrees of confidence which ranged from "having no confidence" to "feeling really confident" . This level of confidence influenced their abilities to obtain information from their health care providers. Various strategies to obtain information from health care providers were noted to include questioning, probing, requesting, and on one occasion a participant felt like she had to "demand" truthful information. Some women perceived that they were met with a degree of "defensive" from their health care providers. This researcher speculates that a power struggle ensued between birth participants, not because of the characteristics of the individual women and their partners, but due to the characteristics of the labor and delivery ward. Characteristics of the ward, or "order of the ward" was reported by Kirkham (1989) to be "the intangible but very real patterning of mood and sentiment that characteristically exists on each ward" (p.122). Information represented "power" and the struggle for power between birth participants was a serious consideration in the category of "negotiated order" (p.122).

In this study it is interesting to note that several of the participants had student learners or nurses who attended them during childbirth. In these situations, two participants described having to either "wait" for information or not being provided with sufficient information. In one scenario, however, an inexperienced staff nurse openly sought guidance from an experienced staff member to ascertain that the information provided to Carlynn was both adequate and appropriate. These findings are corroborated by the findings from Kirkham (1989) in which student midwives and junior staff were aware of their inexperience and learned very rapidly the techniques for blocking and controlling the provision of information. Although they did give information to laboring women it was recognized to be in "short spurts", and when the sister was not available to check that the information was correct or improve the student's communication skills. Kirkham stated that "in the sense of teaching or help from those with experience, midwives remained inexperienced in this respect long after they were qualified" (p. 126).

Kari and Julia stated that although they were surrounded by hospital staff members during labor and birth, they were given limited or no information regarding their "uncertain" status and progress. In both of these birth scenarios, these women were only provided with this critical information from their obstetricians. It was apparent that more junior staff members were socialized to "say nothing and be safe" rather than to risk providing information which was not appropriate. These findings are consistent with those of Kirkham (1989) who reported that there was an understanding in the birthing units that "technical" information was only provided by senior staff members.

Inaccurate information is another significant way of communicating which emerged from the experiences of women in the study, as it conveyed facts, knowledge or news that was not complete or truthful. The consequences of providing incomplete or untruthful information to laboring women are inconceivable as labor has been identified as a time when women are most "vulnerable". Simkin (1991) declared: "a woman in labor is highly vulnerable. Her most private body parts are exposed, she is in pain; she sweats, trembles and moans..." (p.310). It is not surprising that women who received inaccurate or untruthful information from their care providers described depersonalized feelings such as "like a slab of meat", "like a freak", and "we were floundering in the dark", along with feelings of distrust and disrespect for their birth attendants.

Explanation and Lack of Explanation

Explanation was a type of communication which further clarified and simplified information given to women in the study and was achieved by explaining rationales, procedures, and results of examinations. These ways of communication were perceived to have positive outcomes which included: decreased anxiety; enhanced understanding and knowledge; increased control and comfort; increased participation in decision making; and, involvement in planning and choosing. It is apparent that adequate explanations must be provided in addition to information-giving, in order for women to clearly understand the principles behind birthing actions and behaviors, procedures, and results of examinations. This understanding facilitated involvement in decision making and the opportunity for choice.

Lack of explanation did not provide clarification or simplification of the meanings of information given to women in the study, and it is not known if these miscommunications occurred as errors of omission or were intentional. "Policy" statements were offered when mandatory compliance of institutional policies were necessary, rather than the provision of appropriate rationale. The lack of explanation of procedures and examination results by health care providers increased client's vulnerability and maintained the health care provider's power and control. It is this researcher's contention based on experience, that some health care providers may not know the reasons "why" specific physiological behaviors occur or are uncertain of the rationales behind procedures and examinations.

Fleissig (1993) conducted a postnatal survey of women who had recently given birth in England and Wales to explore their views on information provided to them during childbirth. The term "information" utilized by Fleissig was more specific to the definition of explanation identified in this study, as it specifically related to explanations of technical procedures. She reported that 81% of women surveyed thought the hospital staff "explained enough" and 18% of women "wanted more information". In addition, Fleissig suggested that health care providers had difficulty in communicating with single mothers and those belonging to minority groups. As women in this study were neither single mothers or members of a minority group, these findings can not be corroborated.

Reassurance and Lack of Reassurance

Reassurance referred to the restoration of courage and confidence to women in the study, and included, confirmation and encouragement. Several of the participant's received confirmation and support that they were progressing appropriately throughout the stages of childbirth. Other women were given assistance and optimism pertaining to their ideas and, most importantly, their efforts during childbirth. These ways of communication were most often granted by staff nurses which corresponded to women's expectations of the roles of nurses as providers of support and guidance. This finding is particularly significant for women who described that they lacked confidence or doubted their ability to birth, as they reported decreased anxiety; increased control, comfort, and support; and, feelings of inclusion, acceptance, and being "cared for".

Lack of reassurance was identified as a lack of promotion of courage and confidence. The ways in which this ineffective communication was achieved included, false reassurance and no reassurance. False reassurance consisted of limited statements which were perceived to defend care providers authority in the hospital setting. These justifications appeared to fulfill the needs of the health care providers rather than those of the laboring woman. These findings are consistent with findings from Kirkham (1989) who reported a category called "self reassurance", in which midwives used patterns of speech that "appeared to reassure themselves that the woman in their care was comfortable and that her needs were being met" (p.130).

No reassurance was recognized as the lack of assistance, optimism, and recognition of the client's efforts during labor and birth. This way of communicating was reported to evoke feelings of disappointment, frustration, fear, and decreased control. In many cases, women described losing control and noted that their health care providers attempted to gain control of the situation by focusing on the task at hand. A Canadian study by Beaton (1990), which explored the dimensions of nurse and patient interactions in labor, supports this finding. Beaton reported that "acquiescence", the viewpoint or definition of reality which predominates in the interaction, was low for nurses with respect to understanding the comfort of laboring women. When these women were in need of support or confidence, the nurse used her own perspective of the situation to "implement what she considered to be the appropriate course of action" (p. 403), which were most often task-oriented measures.

Attending and Non-Attending

Attending referred to the attentiveness of health care providers, and their ability to align themselves physically and psychologically to women and was achieved through chatting, listening, tone of voice, addressing feelings and concerns, and asking preferences. These ways of communicating were perceived by women in the study as elements of a "caring" relationship, and were described as calming, conveying interest and respect, increasing confidence, and increasing feelings of involvement in the birth process. Attending skills utilized by health care providers reflected commitment and woman-directed care, communicating a sense of openness which encouraged participation and freedom of choice. These findings are supported by Swanson's (1991) theory of caring from numerous perinatal studies. Swanson defined caring as nurturing and relating to others' values with a personal sense of commitment and responsibility, and identified five categories of caring which facilitated a "caring process". These categories included: knowing, being with, doing for, enabling, and maintaining belief. Although these categories were not specifically explicated by women in the study, it serves to substantiate many of the caring actions described in the study.

Non-attending was identified as the lack of attending skills care providers utilized when they were unable or not willing to align themselves physically or psychologically to women in the study. These ways of communication included: lack of dialogue, not listening, rushing, rejecting, failure to ask client, assumes knowledge, and "told to". Feelings of anxiety, insignificance, frustration, anger, abandonment, exclusion, dependency, and incompetency were reported as outcomes when these ways of communication were practiced by care providers. "Rushing" was a common description by most of the women in the study. In our society, time is a valuable measure and spending time with someone is a reflection of their worth. It is not surprising to discover that women who were "rushed" reported feelings of insignificance, abandonment, and frustration. It is this researcher's contention that attending skills which did not support women's self-worth during childbirth would affect their ability to make choices or actively seek involvement in decision making.

Taylor, Pickens & Geden (1989) studied the interactional styles of physicians and clients during decision making. Interactional styles, or the styles in which information was presented to clients, was noted to vary and includes "shared decision making", "paternalistic", and "maternalistic". Shared decision making occurs when the client's autonomy and ability to make choices are respected. Paternalistic interaction transpires when physicians present possible alternatives but personally select the course of action and maternalistic interaction occurs when consequences rather than alternatives are given to clients. Although Taylor et al's research was conducted with physicians, it is not unrealistic to accept that these interaction styles are reflective of all health care professionals who provide information to health care consumers. Interaction styles appear to be an important component of care provider's attending and non-attending skills and further exploration in this area is warranted.

Rhodes (1983) argues that the 'beurocratic model' of childbirth dictates that the running of the organization is top priority and that the individual client's needs are subordinate to the needs of the institution. The hospital as an institution has goals which are mutually exclusive from those of individual, laboring women. Richards (1982) comments that the "power politics of birth" in traditional obstetrics in very unequal and inhibits the provision of woman-centred care (p. 258). Policies are not often developed to satisfy the self-perceived needs of individual clients (Beaton, 1990). Institutional realities such as shift work, staffing, routine procedures, and handing responsibility over to others prevents the humane and compassionate attending that should characterize all births (Richards, 1982; Beaton, 1990; Kirkham, 1989).

Control and Decision Making Behaviors

Participants expressed their concerns and experiences associated with childbirth, which emerged from their attempts to balance the effects of uncertainty and control. Uncertainty was seen as undesirable and control was viewed as desirable. Anxieties related to uncertainty and "loss of control" were reported by all of the women in the study and encompassed loss of control over their physical bodies and loss of control over their identities in the hospital environment. Women stated that they "lost control" over their bodies when they experienced unexpected events such as fetal distress, cesarean section, and labor and birth pain. Loss of control over their identities in the hospital environment was associated with recent health care reforms in this province, multiple care providers, routine childbirth procedures, and ineffective communication patterns. These findings were consistent with those from Kirkham (1989) who reported that women in her sample sought information related to uncertainty on two levels; uncertainties regarding the "physiological unknown of labor" and the "hospital environment and conduct", which included social, technical, and geographical elements (p. 120).

Control, an important theme, was related not only to the location of birth, but also to control over one's birth experience, and control held by health care providers in the institutional setting. Women described control as their freedom to choose and influence what happened to them. Control related to those behaviors which fostered their ability to maintain or attain control during childbirth such as possessing self-confidence, confronting issues and concerns, expressing thoughts and feelings, considering self to have health care rights, and making own choices. Two participants who consistently demonstrated collaborative behaviors preferred to be actively involved in collaboration with their health care providers, in both decision making and taking responsibility during birth. Although these women also expressed concerns regarding "losing control" due to the uncertainties associated with childbirth, their behaviors reflected a will to "gain control" at every possible opportunity.

The concept of 'control' has been studied by numerous childbirth researchers on many dimensions in an attempt to further understand it's significance with participation in decision making, and many of the findings are consistent with findings from this study. Chute (1985), Davenport-Slack and Boylan (1974), and Willmith (1975) reported that childbearing women perceived themselves 'in control' if they felt they were active participants in childbirth rather than passive recipients of care. Active participation was interpreted to mean that women felt they were able to negotiate and influence decisions during childbirth. Butani and Hodnett (1980) reported that not all women in their study expressed a desire to 'be in control'. Two other participants in this study exhibited primarily passive behaviors during childbirth and preferred a lesser role of involvement and responsibility in making decisions related to their care.

These women also expressed a lack of self-confidence and anxieties regarding "losing control" in childbirth.

Outcomes

Women in the study were deliberately not asked about their satisfaction with childbirth. Satisfaction in childbirth is a complex multi-dimensional construct and presents several methodological problems (Bramadat & Driedger, 1993; Green, Coupland & Kitzinger, 1990), although it was noted to be the subject of numerous studies in the past two decades. Instead, women were asked to describe their childbirth experiences. The responses received by the women were in reference to achieving their childbirth goals and their perceptions of communication skills practiced by their health care providers during childbirth.

Positive Birth Experiences

Six of the women in the study viewed their birth experiences in a positive manner, as they were successful in achieving their goals and were content with their various levels of participation in decision making with their care providers. Each of these women described the growth of a therapeutic relationship with their care providers, which was facilitated and nurtured by a broad range of effective communication skills, including information-giving, explanations, reassurance, and attending.

Carlynn and Lauren adopted passive decision making roles and relied on their health care providers to chose their activities for them. Although they did not seek to collaborate in making decisions or responsibility for their births, both women described feeling a 'part of the team' as they were consistently informed of their progress and status during childbirth. Anna, Mackenzie, and Madeline actively planned their births and sought opportunities to be involved in decision making in collaboration with their care providers. These women chose "trusted" health care providers who would accommodate their preferences and provide them with childbirth options. Jenny's experience was unique in that she was unable to establish a relationship with her primary physician during her pregnancy due to ineffective communication patterns and lack of continuity of care. She was "dreading" her impending birth and wanted to "stay pregnant for a while longer", however, she had an unexpected, positive birth experience when her primary physician was away and the attending health care providers were responsive to her needs.

The findings related to various levels of preferred involvement in decision making are supported by Littlefield and Adams (1987), who stated that women varied in their desired amount of participation in decision making during childbirth. Some of the participants in their sample preferred to be actively involved in decision making and others reported a great reliance and dependency on their health care providers to make decisions.

Negative Birth Experiences

The other six women in the study described their birth experiences as negative for reasons which included their inability to achieve birthing goals, ineffective communication patterns and lack of continuity of care. Demi, Sandy, and Allison were unable to establish a rapport with their multiple health care providers and were disappointed in the lack of information, explanations, and reassurance they received during childbirth.

Sandy and Tracey asserted that their birth preferences were met with a degree of resistance and defensiveness, and believed that they had to assert themselves in order to make limited choices involving their care. Both of these women compared their birth experiences to a battle in which they had "to fight and argue for what we wanted" (Tracey, B, line 293). In a retrospective study of 1508 postpartum women by Jacoby (1987), it was found that a large majority of women did not have their birth preferences, for or against obstetrical interventions, met during childbirth.

Demi, Kari, and Julia were 'the last ones to know' information related to their status and progress in labor. Demi was excluded from information by the large number of student learners who were unwilling or unable to convey appropriate information. Kari and Julia felt depersonalized and angry when they were not given information, explanations, and reassurance regarding the uncertain status of their babies in labor. As well, these women experienced the effects of non-attending skills when their care providers did not listen, rejected them, did not ask how they were feeling, and told them to perform specific actions and behaviors, without providing any explanations.

It is not surprising that these women were unable to perceive the presence of a relationship with their health care providers. Feelings of fear, anxiety, anger, insignificance, and depersonalization emanated from their birthing experiences. These women did not achieve their birthing goals, nor were they able to engage in the level of involvement in decision making they had desired.

Despite feeling disappointed with their birth experiences and describing them in a negative manner, two of the women in the study offered excuses for their health care providers. Demi and Sandy excused the ineffective communication patterns and inappropriate behaviors demonstrated by their care providers. Julia was also terribly disappointed with her birth experience and did not excuse her health care providers for their consistent ineffective communication and inept behaviors. It appears that the birth of a healthy child created a willingness to excuse the behaviors of their carers. This finding is consistent with that found by Bramadat & Drieger (1993) and has been described as the 'halo effect', in which women are reluctant to criticize their care givers and excuse their behaviors. Riley (1977) also states that most women may not "mind greatly" about what has happened to them, especially in their relief and pleasure at having produced an intact child. Julia did not excuse the behaviors of her health care providers

Limitations of the Study

Participants in the study had diverse childbirth histories, with the majority of women being multigravidas and five being primigravidas. Some of the women had experienced obstetrician and family physician-attended births; one woman had a hospital birth attended by both a midwife and physician, and the other had a midwife-attended home birth. The sample was deliberately selected to represent a wide range of past experiences and to represent both traditional and alternative practice. The sample was relatively homogeneous in terms of cultural background. Although two of the participants were born overseas, both women were raised in Canada and it was not possible to examine potential cultural differences. It is likely that women's expectations and experiences of decision making and communication in childbirth is dependent on culture and its influence on perceptions of birth.

Although the researcher had initially planned to observe all of the communication and decision making interactions between participants and their care providers during childbirth, this was not possible. For reasons related to health care providers increased anxiety due to recent health care reforms, the researcher was not allowed access into the institution. Further studies which include observation would assist researchers to further understand the experiences of women's decision making and communication during childbirth.

Implications for Research, Education and Practice

The findings from this study have strong research, education, and practice implications for all professions who care for childbearing women, including medicine, midwifery, and nursing. There are also implications for health care policy administrators and other health professionals with whom these professions practice in a cooperative manner.

Research

The participants in this study were relatively homogeneous in their articulate reporting of their experiences. They were also similar in relation to their marital status, education, employment, and prenatal education. The study of a more heterogeneous group of women could produce more generalizable findings and further develop knowledge related to women's expectations and experiences of decision making and communication during childbirth.

In this study the communication patterns between the two women who had midwives as their care givers demonstrated a more collaborative pattern of communication. Whether this is due in part to the different characteristics of the women who actively sought a means of achieving their goals can not be determined from this study. There is a need for studies which examine both the characteristics of women and health care professionals to contribute to this body of knowledge.

Further knowledge about health care professional's values and attitudes regarding childbearing women's roles and expectations for participation in decision making is imperative. The knowledge and explanations which influence values related to decision making is necessary to vary the mode of professional practice and to transform health care professionals interactions with childbearing women into essential means of achieving their birth goals.

Because the profession of midwifery in Canada is just beginning to emerge, additional research into the role of the midwife is necessary. There appears to be different international practices among populations and health care systems, and the unique roles of midwives must be examined and substantiated in order to fully describe their scope of practice and care.

A final recommendation for further research would be a study which explores the differences in women's perceptions of decision making and communication between midwives and traditional health care providers. Such a study would reveal additional information for all health care professionals to understand and facilitate effective communication patterns and preferred levels of participation in decision making during childbirth.

Education

For decades most educational programmes for health care professionals have included in their curricula the topic of communication and have recognized its value in a variety of settings (Olds, London & Ladewig, 1984). However, the findings from this and other studies show that interpersonal competence of many health care providers is low, hence emphasis on the teaching of these effective and ineffective communication patterns in educational institutions should become a priority.

Education programmes for health care professionals should also include in their curricula the body of knowledge surrounding decision making skills, including a discussion on the experiences of clients who seek various levels of involvement in decisions affecting their care. Until health care professionals are equipped with knowledge of decision making skills and the understanding that women vary in their self-perceived needs and expectations, the traditional and often technocratic approach to working with childbearing women will continue.

Midwifery care is not presently an option for many women in this province because of factors which restrict choice, such as lack of funding for midwives in the health care delivery system, and lack of midwifery educational programmes. Two of the women in this study overcame these obstacles. All women should be able to choose a primary maternity carer who best suits her needs.

Midwives and midwifery supporters must educate the general public about the current legal status of midwifery in Alberta, professional midwifery education, midwives' scope of practice and competency, and the benefits and limitations of midwifery care.

Clinical Practice

This study has many implications for those who attend childbearing women. All health care providers who come into contact with childbearing women need to use sound knowledge about the experience of decision making and communication patterns during the childbearing cycle. Through in-service education, reports of these research findings, role modeling in practice sessions and supportive working environments, professionals' ideas about identifying the level of decision making childbearing women desire and utilizing more effective patterns of communication should change.

The traditional professional approaches to working with women and decision making, specifically, not identifying childbearing women's needs or acknowledging that women may or may not want to participate in making decision related to their care, are neither helpful nor acceptable as indicated by data in this study. Health care professionals need to assess and identify their own decision making skills in order to increase awareness of the impact these skills have on enabling or inhibiting women to be involved in their care. This exercise in self-assessment and care provider's subsequent awareness that decision making skills may only have been of benefit to their own needs, will assist in solving difficulties associated with lack of client-centered care. Each client's desired level of participation must be determined throughout the antenatal period. Specific alternatives about decisions involving care should be provided, explained, and discussed in order to enable women to collaborate in making decisions which best suit their needs.

Practitioners also need to understand and determine their own abilities and limitations in communicating with clients throughout the childbearing cycle. Guidelines which foster the development of therapeutic communication skills, initially involve understanding the dynamics of therapeutic communication and critically examining one's ability for self-growth (Kepler, 1980). The avenues to acquire effective communication patterns including information-giving, explanation, reassurance, and attending and relinquish ineffective communication patterns involve learning, discussion, and the practical use of these skills in contact with clients.

The slogan 'information is power' was a truism among participants in the study. Women's comments support the need for more information from health care providers on their status and how they are progressing throughout the childbearing cycle. Information must be provided in language that can easily be understood to ensure that women are aware of what is happening to them. They need to be aware of the protocols and interventions used in emergencies, and those who are to have such procedures should have them fully explained in advance. Health care professionals need to utilize and value listening to verbal and non-verbal cues as childbearing women may have difficulties expressing their needs and desires or may never have had opportunities to identify their needs. Care providers must encourage their clients to communicate their preferences in meaningful interactions throughout the childbearing cycle in order to facilitate the development of a client-health care professional relationship. At least, women should be asked their birthing preferences upon admission to birthing institutions.

As childbearing women have several issues to contemplate in preparation for childbirth, they require a relaxed, unrushed environment in which they are given time to explore and communicate their needs. It is evident from the findings of this study that "5 minute" antenatal visits do not provide more than a brief physiological assessment at best. These and other barriers which prevent client expression must be identified and resolved by individual practitioners and the opportunity to adequately assess expectant women's psychosocial needs must be made available.

Health care administrators must be aware of the 'power factor' that is intrinsic in the hierarchy of institutional settings and recognize that organizational priorities are often different from the priorities of childbearing women. Barriers which inhibit client-centered care, and are evident in the finding of this study, such as lack of continuity of care, nurse and institutional-related factors must be resolved on a unit level to avoid the reality that clients are receiving depersonalized and dehumanized care.

Lastly, in this study it was discovered that inadequate childbirth care is only mildly criticized, if at all. Health care professionals must provide postpartum women with the opportunity to discuss their perceptions of their birthing experiences. Complaints or expressions of negative birth experiences may have profound psychological implications on childbearing women beyond the immediate postpartum period and include decreased maternal self-esteem (Oakley, 1977), postpartum depression (Oakley, 1980), and impaired bonding (Harper, 1994).

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Appendix A

PUBLIC NOTICE

I AM A MATERNITY NURSE-RESEARCHER AND I
WOULD LIKE TO TALK TO PREGNANT WOMEN AND THEIR PARTNERS
(IF POSSIBLE) ABOUT THEIR BIRTH EXPECTATIONS
AND THEIR BIRTH EXPERIENCES.

IF YOU ARE IN YOUR LAST 4 WEEKS OF PREGNANCY AND WOULD LIKE TO
PARTICIPATE OR WOULD LIKE MORE INFORMATION,
PLEASE CALL SUSAN AT 439-8769.

Appendix B

Information Letter for Potential Participants

Project Title: Communication and Decision Making During Childbirth.

Researcher:	Susan Beischel MN Candidate Faculty of Nursing University of Alberta Phone: (403) 439 - 8769	**Supervisor:**	Dr. P.A. Field Professor Faculty of Nursing University of Alberta Phone: (403) 492 - 6248

The purpose of this study is to learn how women make their decisions known to health care providers during labor and birth. You must be in the last 4 weeks of pregnancy and must have had a normal pregnancy so far. If you volunteer to take part in the study, you will be interviewed two or possibly three times. The interviews will be set at a time and place that is best for you and will last for about one hour. In the first interview I will ask a few questions about yourself, your background and how you are planning your labor and birth. The second interview will take place 10 - 14 days after your baby is born. I will ask questions about your experience making decisions in childbirth. A third interview or phone call may be requested to talk more about the data. The interviews will be tape-recorded but your name will not be used. You will be given a code name.

A secretary will listen to the tapes and make typed reports of them. Only the researcher and my committee members will read the typed information. I am the only person who will know who you are. All forms that have your name on them will be locked in a cabinet. The tapes and typed information will also be locked in a separate cabinet. The tapes will be destroyed seven years after the study is completed. The information and your comments will be used to write reports or shared with other health care professionals.

You are free to take part in the study. You can choose to leave at any time and refuse to answer any questions. If you tell the researcher about any problems that are harmful to you, she will discuss these with you. There are no direct benefits for you by taking part in the study. The information you provide may help health care providers learn how women make decisions and communicate in childbirth.

If you are interested in participating or have any questions about the study, please call the researcher or her supervisor at the numbers above.

Thank you for your time and consideration of my request.

Appendix C

Biographical Information Form

Date : ____________________

Pseudonym : ________________

(1) YOUR AGE : (years): ________

(2) YOUR PARTNERS AGE : (years): ________

(3) EDUCATION : (highest level completed)

Junior High   High School   College/University Degree   Graduate Studies

(5) OCCUPATION : (either current or previous) ____________________

(6) HAVE YOU ALWAYS LIVED IN CANADA? : Yes/No. **If NO**, ...

(6 a) WHERE DID YOUR PARENTS COME FROM? ____________________

(6 b) HOW LONG HAS YOUR FAMILY BEEN IN CANADA? ______________

(7) FAMILY INCOME :

less than $10,000 ____
$10,000 - $19,999 ____
$20,000 - $29,999 ____
$30,000 - $39,999 ____

$40,000 - $49,999 ____
$50,000 - $59,000 ____
$60,000 + ____
not specified ____

(8 a) DID YOU ATTEND PRENATAL CLASSES? : Yes/No. If Yes, Where?

____

(8 b) DID YOU OBTAIN INFORMATION ABOUT LABOR AND BIRTH FROM OTHER RESOURCES (books, friends, family, school)? Yes/No.

If YES, WHAT RESOURCES DID YOU USE?

____

Appendix D

Participant Consent Form

Project Title: Communication and Decision Making During Childbirth.

Researcher:	Susan R. Beischel MN Candidate Faculty of Nursing University of Alberta (403) 439 - 8769	**Supervisor:**	Dr. P.A. Field Professor Faculty of Nursing University of Alberta (403) 492 - 6248

The purpose of this study is to explore how women make their decisions known to health care providers during childbirth. The focus is on your experience of making choices and decisions during your labor and birth.

Your participation in this study will involve the following:

- The researcher will interview you two or possibly three times.
- The first interview will be in your last four weeks of pregnancy.
- The second interview will be 10-14 days after your baby is born.
- The interviews will take place at a convenient time and place for you.
- The interviews will last about one hour.
- All interviews will be tape recorded by the researcher.

Only the researcher and the secretary will listen to the tapes. Research committee members may read the typed interviews. The tapes and typed interviews will be stored in a locked cabinet during the study. All information with your name or telephone number will be locked in another cabinet. This material will be discarded five years after the study is finished. The tapes will be destroyed seven years after the study is complete. The typed interviews may be used for other studies but permission will be obtained before they are used. The researcher may use quotes from the interview(s) in descriptions of the study. You will be given a code name and your real name will never be used.

Your participation in this study is your choice:

- You may refuse to answer any questions during an interview.
- You may stop the interview at any point.
- You may withdraw from the study at any time by telling the researcher and this will not affect your care in hospital.
- Your participation may help other women in the future.

This is to certify that I, ______________________________
(print name)

agree to participate as a volunteer in this study. I am aware of the purpose and what is involved in this study. If I reveal information that suggests there is risk of harm to my child, the researcher will discuss it with me. The researcher is required by law to contact Child Welfare. All other information will remain confidential. I understand I am free to withdraw from the study at any time by telling the researcher. I have been given a copy of this consent form to keep. I can call the researcher at any time if I have questions or concerns.

______________________	______________
(Signature of Participant)	(Date)
______________________	______________
(Signature of Participant)	(Date)
______________________	______________
(Signature of Researcher)	(Date)
______________________	______________
(Signature of Witness)	(Date)

* *

REQUEST FOR SUMMARY: (Optional)

If you wish to receive a summary of the study when it is finished, please complete the following:

Name: ______________________________
Address: ______________________________
____
____

Appendix E

Secondary Participants Informed Consent

Project Title: Communication and Decision Making During Childbirth

Researcher: Susan R. Beischel
MN Candidate
Faculty of Nursing
University of Alberta
(403) 439 - 8769

Supervisor: Dr. P.A. Field
Professor
Faculty of Nursing
University of Alberta
(403) 492 - 6248

The purpose in this study is to explore how women make their decisions known to their health care providers during childbirth. The focus is on your understanding of making choices and decisions during labor and birth.

Your participation in this study will involve the following:

- You will be asked to comment on the researcher's impression of information that was given by other women in the study
- You will be asked to sort out cards into different piles that have words or phrases printed on them.
- You will be asked to talk out loud while you sort out the cards.
- You will not be interviewed and your comments will not be used in the study.
- All sessions will take place at a convenient time and place for you.
- The sessions will last about one-half hour.
- All sessions will be tape recorded by the researcher.

Only the researcher and the typist will listen to the tapes. Research committee members may read the typed pages. The tapes and typed pages will be stored in a locked cabinet during the study and will be destroyed seven years after the study is complete. This consent form will be retained for five years. You will be given a code name and your real name will never be used.

Your participation in this study is your choice. You may stop the session at any point by telling the researcher. Your participation may help other women in the future. You may not directly benefit from being in the study.

This is to certify that I, ____
(print name)

participate as a volunteer in this study. I am aware of the purpose and what is involved in this study. I understand I am free to withdraw from the study at any time by telling the researcher. I have been given a copy of this form to keep. I can call the researcher or her supervisor at any time if I have questions or concerns.

(Signature of Participant)	(Date)
(Signature of Researcher)	(Date)
(Signature of Witness)	(Date)

****

REQUEST FOR SUMMARY: (Optional)

If you wish to receive a summary of the study when it is finished, please complete the following:

Name : ____

Address: ____

____

Appendix F

Sample Questions for the First Interview

In this first interview, I am looking at your expectations of your birth experience.

Tell me how your pregnancy has been to date?

Examples of Descriptive Questions

(1) What do you think will happen during your labor and birth?
(Probe: Where have you acquired your information from? and Have you talked about the possibility of induction of labor, cesarean section, episiotomy?)

(2) Have you thought about your involvement in making decisions during your labor and birth?

Examples of Structural Questions

(1) Tell me what strategies you have thought about that will help you to make decisions and communicate these decisions to your health care providers during your labor and birth?

(2) What will you do if you no one seems willing to listen to the decisions you have made?

Example of Contrast Question

(1) Can you tell me if you think there is a difference between control and decision making?

Appendix G

Sample Questions for the Second Interview

Example of Descriptive Questions

1: Tell me what you remember about your labor and birth experience?

2: How well were you able to carry through your plans for labor and birth? (Probe: What factors facilitated or hindered your plans?).

Example of Structural Questions

1: Did those caring for you provide you with enough information to make decisions that satisfied you during labor and birth?
(Probe: Tell me how health care providers included you in decisions that were made during your labor and birth?)

Example of Contrast Questions

1: Was there a difference between the care that you wanted, that you requested and that you received? (Probe: Focus on communication).

2: If you could change anything about your labor and birth, what would it be?

Appendix H

Health Care Provider Negative Consent Form

Project Title: Communication and Decision Making During Childbirth.

Researcher:	Susan Beischel MN Candidate Faculty of Nursing University of Alberta Edmonton, AB., T6G 2G3 (403) 480 - 3710	**Supervisor:**	Dr. P.A. Field Professor Faculty of Nursing University of Alberta (403) 492 - 6248

From: (Selected Hospital) Maternity Health Care Provider

Date: July 6, 1995

I, ______________________________
(Print Name)

DO NOT WISH to be observed when providing care in the proposed research study entitled "Communication and Decision Making During Childbirth".

____
(Signature)

Staff Position: (Please indicate one of the following)

_____ Physician

_____ Staff Nurse

_____ Resident / Intern

PLEASE NOTE:
If I do not receive this form from you by July 20, 1995 , it will be understood that I may observe you providing care in the research study.

Appendix I

Notice of Study on Birthing Room Door in Hospital Setting

RESEARCH STUDY IN PROGRESS

PLEASE REFER TO NURSING STATION FOR ADDITIONAL INFORMATION

Appendix J

Health Care Provider Consent Form

Project Title: Communication and Decision Making During Childbirth.

Researcher:
Susan R. Beischel
MN Candidate
Faculty of Nursing
University of Alberta
(403) 480 - 3710

Supervisor:
Dr. P.A. Field
Professor
Faculty of Nursing
University of Alberta
(403) 492 - 6248

The purpose in this study is to explore how women make their decisions known to health care providers during childbirth. The focus is on women's experience of making choices during their labors and births.

Your participation in this study will involve being observed while you provide care during labor and birth. Observation will be used to further understand the information provided by women. The researcher will arrive at the hospital when the participant is admitted in labor and will only observe and take notes during labor and birth. The researcher will not participate in the labor or birth as a support person.

All notes pertaining to the study will be transcribed by a typist. Research committee members may read the typed notes. The typed notes will be stored in a locked cabinet during the study and destroyed seven years after the study is complete. The researcher may use quotes from the notes in descriptions of the study. You will not be identified by name, rather you will be identified by your staff position of physician, nurse, or resident. This consent form will be stored in a separate locked cabinet and retained for five years.

Your participation in this study is your choice. If you are not comfortable being observed, the researcher will leave the room for the period of time you are providing care to the laboring woman. Your refusal to participate will not affect you employment status at the Royal Alexandra Hospital. If you have any questions or concerns about the study you may speak directly to the researcher, or call her or her supervisor at the numbers provided above.

I acknowledge that I understand the purpose of the research study and have had all questions about the study fully answered. I understand that my participation in this study is voluntary and will not affect my employment status at the Royal Alexandra Hospital. I have been given a copy of this form.

(Signature of Health Care Provider)	(Date)
(Signature of Researcher)	(Date)

Appendix K

Information Letter for Health Care Providers

Project Title: Communication and Decision Making During Childbirth.

Researcher:	Susan Beischel MN Candidate Faculty of Nursing University of Alberta (403) 480 - 3710	**Supervisor:**	Dr. P.A. Field Professor Faculty of Nursing University of Alberta (403) 492 - 6248

Dear Health Care Provider,

I am a Master's of Nursing candidate at the University of Alberta and my thesis proposal involves exploring how women make their decisions known to health care providers during childbirth. The focus is on women's experiences of making choices during their labors and births. I have received ethical approval from the University of Alberta, Faculty of Nursing and the Royal Alexandra Investigational Review Committees to conduct this research.

Your participation in this study will involve being observed while you provide care during labor and birth. Observation will assist the researcher to further understand information provided by women. The researcher will arrive at the hospital when the participant is admitted in labor. The researcher will only observe and take notes during labor and birth. The researcher will not participate as labor support or coach in the labor and birth.

All notes pertaining to the labor and birth will be transcribed by a typist. Research committee members may read the typed notes. The typed notes will be stored in a locked cabinet during the study and destroyed seven years after the study is complete. The researcher may use quotes from the notes in descriptions of the study. You will not be identified by name, rather by your staff position of physician, nurse or resident.

Your participation in this study is your choice. If you are not comfortable being observed providing care for laboring women, please return the enclosed form in the stamped, addressed envelope that has been provided. This information will only be known to the researcher and will not affect your employment status at the (Selected) Hospital. If you have any questions please contact me or my supervisor at the numbers provided above.

If I do not receive the enclosed Negative Consent form from you by July 20, 1995, it will be understood that I may observe you providing care in the proposed research study.

Thank you for your time and consideration of my request.